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ABSTRACT

Discussed are practical factors involved in planning and carrying out child abuse and neglect treatment programs. It is explained that the information is based on the experience of 11 demonstration projects in 10 states. Chapter 1 details planning theories and offers a model for program planning. Chapter 2 is designed to inform planners of typical problems involved, such as management concerns and difficulties in relating to the community. Needs assessment is the subject of chapter three, and sample questions are listed. Methods for identifying and clarifying goals are explored in chapter 4. Examined in chapter 5 are alternative organizational models and staffing patterns for child abuse and neglect treatment programs. Analyzed in chapter 6 is the range of treatment approaches available, such as the criminal justice, psychiatric, anthropological, group dynamics, and supportive and advocacy approaches. Chapter 7 deals with the essential elements of case management and the information maintained on clients. An accounting method for monitoring resource expenditures is provided in chapter 8. The final chapter deals with the program's relationship to the community. Case studies of four child abuse and neglect treatment programs are appended. (CL)

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PLANNING AND IMPLEMENTING CHILD ABUSE AND NEGLECT SERVICE PROGRAMS:
The Experience of Eleven Demonstration Projects

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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FOREWORD

This booklet is based on the experience of eleven jointly-funded demonstration child abuse and neglect treatment projects. We in the Federal Government are proud of the joint nature of this important demonstration program because of the example it sets for federal coordination and cooperation. The projects were funded by two federal agencies, the Office of Child Development and the Social and Rehabilitation Service and evaluated by a third, the National Center for Health Services Research.

The projects helped people in ten different States, and involved the efforts of six public departments of social services, two community hospitals, two community voluntary agencies, one department of education, and one Indian tribal council. All projects have utilized a staff with a range of professional and para-professional backgrounds working together to provide appropriate services to abused and neglected children and their families.

On the basis of the experience of these eleven projects, four essential elements for good program development have been identified: (1) overall community needs must be assessed before the program is initiated, (2) goals and objectives of any project must be clearly stated before the project is commenced, (3) performance standards by case management and treatment must be established in the first stages of program operation, and (4) on-going monitoring of program expenditures and effectiveness is the key to long-term success.

This booklet is certainly not a complete or final answer to the problems of providing appropriate services to children and families, but we hope that the experience of these eleven projects, as distilled in this publication, will provide assistance to those communities seeking new or improved programs to help protect our nation's endangered children and to help their troubled parents.

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INTRODUCTION

Berkeley Planning Associates has written PLANNING AND IMPLEMENTING CHILD ABUSE AND NEGLECT SERVICE PROGRAMS: The Experience of Eleven Demonstration Projects for those planning to embark on the development of new programs in the field. These materials have been developed in conjunction with an evaluation effort funded by the Health Resources Administration, Department of Health, Education, and Welfare, of eleven child abuse and neglect demonstration projects. These projects are funded jointly by the Children's Bureau of the Office of Child Development and Social and Rehabilitation Service, also of D/HEW.

The purpose of this document is to assist individuals planning or operating service programs in child abuse and neglect. It should also be useful to those planning other kinds of social service programs. The document reflects the experiences of many community child abuse and neglect demonstration programs and service systems across the country. It provides a compact review of the fundamental issues that should be addressed by those interested in establishing programs for the alleviation of child maltreatment.

The authors hope that this document will be useful to the program planner in a number of different ways. It can help in determining the service needs within a given community. It can be a guide in identifying program goals and objectives. The document outlines the range of models and specific treatment strategies a program might adopt and can, therefore, aid in the design of a program. Performance standards for case management and treatment, and methods for monitoring program resource expenditures are presented as issues of concern to program managers. Methods for working with the community agencies or groups are explored. Finally, case studies of four existing child abuse and neglect service programs are appended as real-world examples of many of the issues discussed in the main body of the document.

Although child abuse and neglect are by no means new problems, until recently there have been very few programs that dealt specifically with them. Little is known about the causes of child abuse and neglect, about which treatment services are most effective, about what kinds of workers should provide services, and about how they should be trained. The field is still very young. Since this document has been developed at a time when knowledge is limited, it is not the final word on what programs should be like. Instead, the document presents issues and questions that program planners should consider prior to designing their programs.

The ideas presented here are those of the Berkeley Planning Associates staff and not necessarily the opinions of the federal government. Formal guidelines for child abuse and neglect service programs are currently being developed by the National Center on Child Abuse and Neglect of the U.S. Children's Bureau.

Readers may be interested in obtaining additional information, not covered in this document, about child abuse and neglect programs. The National Center on Child Abuse and Neglect of the Children's Bureau in Washington, D.C. can be an invaluable resource to those in the field. It has listings of all currently funded demonstration programs in the child abuse and neglect field, annotated bibliographies on abuse and neglect, as well as information on other ongoing activities in the field.

We wish, at this time, to thank several people who have assisted the evaluation staff in compiling this document. The directors and staff of the eleven demonstration projects currently being evaluated by Berkeley Planning Associates shared with us their experiences in implementing new programs in the child abuse and neglect field. These have become the basis of many discussions in the document. The director and staff members of the Extended Family Center in San Francisco, a former Children's Bureau child abuse demonstration service program, also offered many insights into the dynamics of setting up a new program. Elsa TenBroeck, Elizabeth Davoren and Eli Newberger, consultants to Berkeley Planning Associates, provided valuable suggestions for and criticisms of this document. Feather Hair from Health Resources Administration, Cecelia Sudia, Douglas Besharov and Betty Simmons from the Office of Child Development, and other members of the Department of Health, Education, and Welfare's Interdepartmental Committee on Child Abuse and Neglect also provided useful suggestions. Penny Barkin thoroughly edited the manuscript and Donna Gara has carefully typed it. Finally, other members of the Berkeley Planning Associates staff, including Katherine Armstrong, Linda Barrett, Donald Clemons, Frederick C. Collignon and Todd Everett, provided vauluable in-house review of the document.

Anne Harris Cohn, Project Director
Beverly DeGraaf
Mary Kay Miller
Susan Shea Ridge

June 1976

CHAPTER I: PLANNING: SOME THEORY, BEFORE IMPLEMENTING A PROGRAM

This document attempts to offer, in a compact format, assistance to those who may soon undertake to plan their own child abuse and neglect service programs. It outlines the major processes involved and some of the options to be considered. In a separate chapter some of the problems or pitfalls which others have encountered are presented, with the hope that program planners may be able to avoid them.

One of the major problems in program implementation, however, seems to merit a chapter to itself: that is, the need for program developers to have a good grounding in the elements of program planning -- the steps required and the importance of each step. While it is not possible in this chapter to provide an exhaustive review of different program planning methods, we set forth some of the basic and essential elements of program planning, presenting a schema for understanding the program planning process. Because program planning is a political process, we first discuss strategies for accomplishing planning within a political context.

Working Within a Political Context

The planning process is a political one and as such must take place within the context of a community's political environment. Ignoring political issues invariably results in unsuccessful planning. The astute planner will try to keep abreast of what is happening in the community, while touching base with power centers, potential funding sources, and others who will be important in later stages of program implementation (such as those who might refer clients or provide volunteer services). The key is letting people know what you are planning, soliciting their ideas, and being aware of the interests of others while working with them to help ensure a program's success.

The planner can become familiar with the community's dynamics by reading relevant documents such as the local daily newspaper or the minutes of local government bodies' meetings, as well as by keeping in contact with those who are active in the community. Among the obvious agencies to contact are the local protective services department, the children's hospital, the police and/or sheriff's department, the public health department, the juvenile court, day care programs, the Mayor's office, as well as United Way and other local funding groups. In addition, each region of the country now has a federally-funded Regional Child Abuse and Neglect Resource Center and an Office of Child Development and Social and Rehabilitation Service Child Abuse Designee within

the regional Health, Education, and Welfare Department. Such groups and individuals can be particularly useful in keeping the planner informed of other local child abuse and neglect activities.

Keeping abreast of what is happening state-wide and nationally is also important. The federal National Center on Child Abuse and Neglect Report is an example of many currently published documents that can assist in this effort.

Perhaps most important is letting others in the community know what you are planning. Because of the emotional nature of the problem, and the high level of social concern, program planners will not find it difficult to attract a number of political supports. In order to develop that support, however, word must go out about your plans. Effective public relations and real efforts to contact and work with the appropriate people are invaluable.

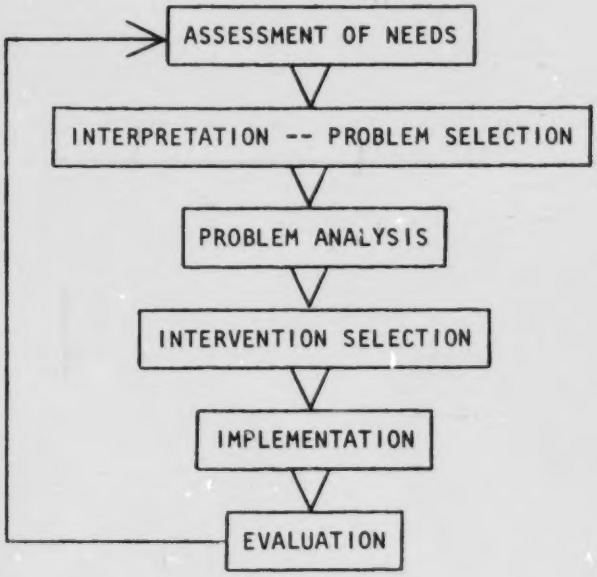
A Model for Program Planning

Table I-A depicts the steps in the program planning process.

The first step in the program planning process is typically a Needs Assessment. As discussed in detail in Chapter II, a needs assessment is the compilation of opinions and information necessary to determine the status quo and identify problems or unmet needs. In this sense, a needs assessment is like a signal system which, on the basis of information collected, suggests or flags where interventions ought to be made. What gaps or duplications exist within the system? Where is the system inefficient? Where is the handling of cases, the provision of services, or the recruitment of workers getting bogged down? Are professionals or the general public lacking in knowledge or expertise about the problem under consideration?

General rules for conducting a needs assessment are (a) to think comprehensively (to be concerned with all systems that might influence the situation of concern), (b) to think prospectively (to be concerned not just with the past and the current situation, but also with the probable future), and (c) to involve many different perspectives (to include those representing different disciplines and agencies). In addition to providing insights into areas of appropriate intervention, the assessment will also provide a basis for ultimately evaluating the appropriateness and effectiveness of the intervention selected.

TABLE I-A: STEPS IN THE PLANNING PROCESS*



The second step in program planning is Interpretation or Problem Selection. Having identified the range of existing problems, one must then decide which will be the area of focus. Since no one program can generally expect to attack all problems, it is best to develop specific criteria by which to judge the importance of the various problems. The criteria should reflect the values and concerns of those who can affect, or are affected by, the situation.

Having identified the principal problem(s), the third planning step is Problem Analysis, that is, analyzing the problem in terms of alternative intervention points. A given problem will have numerous possible solutions. A useful approach to problem analysis is to identify all of the "inputs and outputs," or causes and effects, of the problem. By assessing all of the different precursors to and consequences of the problem, areas of possible intervention will present themselves. In

*As outlined by Henrik Blum in Planning for Health, Human Sciences Press, New York, 1974.

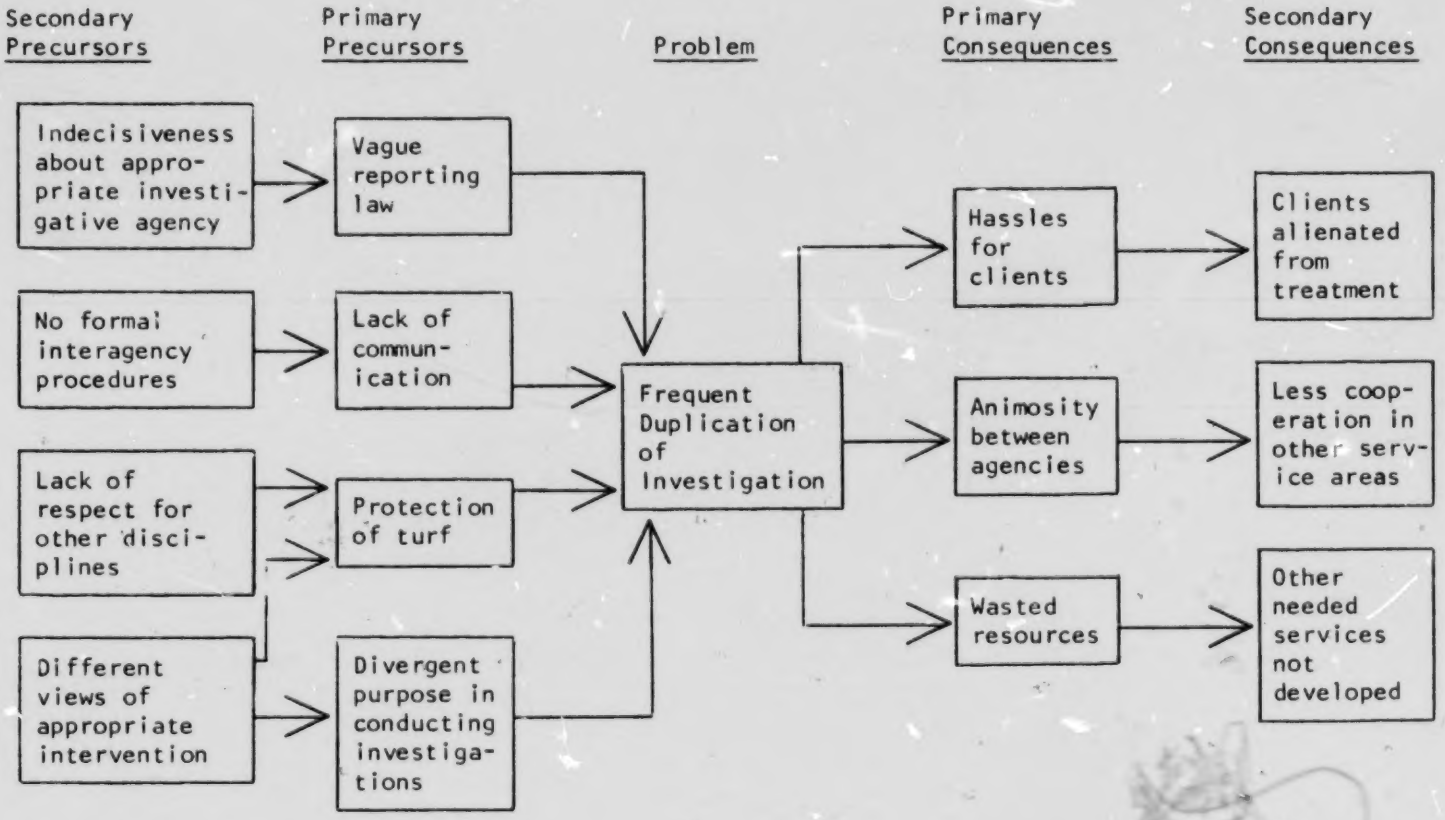
addition, the analyst will gain an understanding of how pressing the problem actually is, that is, whether the consequences are negative to merit intervention. Table I-B is an example of a problem analysis. The problem analyzed is the frequent duplication of investigation; protective services, the police, the local children's hospital and the public health department all simultaneously, but not jointly, investigate the circumstances surrounding the same reported physical abuse case. As the table indicates, primary precursors to this problem include a vague reporting law; lack of communication among agencies; protection of turf by each agency; and divergent purposes in conducting the investigation. Some of the primary consequences of this problem include: animosity between agencies; wasted resources; and unnecessary confusion and conflict for the client. By studying both the primary causes and effects, and the secondary ones, possible areas of intervention become apparent, including: (1) the establishment of a community-wide multidisciplinary diagnostic team or coordinating council to enhance communication between agencies; (2) reform, or more precise interpretation, of the state reporting law; (3) establishment of formal agreements between agencies to conduct joint investigations where possible.

After identifying alternative interventions, the next step in the program planning process is Intervention Selection. The costs and benefits of each alternative should be considered in selecting the most appropriate interventions. How much would it cost to implement a particular intervention? How many dollars are needed? How much effort must be diverted from other activities? How long will the intervention take? What are the benefits of a particular intervention? What additional problems are avoided by intervening at a particular point? By comparing the costs and benefits of alternatives, one intervention or a combination of several will appear as the most desirable.

Program planning, by our definition, includes the actual Implementation of the selected intervention(s). While the planner may not be directly responsible for the program implementation, she/he does have a responsibility for ensuring that the ideas generated are capable of being translated into action.

Finally, Evaluation is an integral part of program planning. Evaluation requires collecting and interpreting information to make judgments about the value or worth of an intervention or program. It is a tool for understanding impact, that is, the extent to which the selected interventions were effective in bringing about the desired changes and thus eliminating or reducing the identified problems.

TABLE I-B: EXAMPLE OF A PROBLEM ANALYSIS



CHAPTER II: IMPLEMENTING A NEW OR EXPANDED PROGRAM

Prior to planning a new child abuse and neglect service or treatment program, it is well to consider what problems lie ahead. Hopefully, awareness of these problems will not deter anyone from attempting to implement a new program, but rather will facilitate the implementation process. The purpose of this chapter is to acquaint the program planner with the types of problems which have been encountered by others in implementing and operating new child abuse and neglect programs. While there are no formulas for success, we have sifted through the experiences of many programs so that others may learn from the errors or problems of a few.

Locating and Using Resources

The first step in the implementation of an already-developed plan for expanding or improving the resources available for child abuse and neglect in a community is a determination of the need for additional funds. It should be stressed that not all new services which have been identified as necessary will require an infusion of resources. Many service components can be developed within the framework of an existing agency with minimal staff re-assignments. Other services might be jointly sponsored by staff of several agencies or programs in a community. Or, ineffective or duplicative services could be eliminated and the funds used to finance the new services which have been planned. Finally, those responsible for developing new services should not overlook the use of volunteers or donated space, equipment, etc. Many very successful projects have been run on a shoestring.

Each of these alternatives, or other feasible approaches, should be tried before a decision to seek additional funds is made. If there is definitely no possibility of funding the desired service innovations through existing sources, clearly new sources of support will have to be sought.

There are several types of funds potentially available from a variety of public and private organizations at the Federal, state and local levels. Many federal programs and private foundations provide start-up money (often called "seed money" or developmental funds) for the purpose of assisting projects to get off the ground. The amount of funding is usually small (often less than is required for program operation, necessitating the addition of matching funds from other sources) and time limited (e.g., six months to one year only). While very useful for the initial development of services, projects with start-up funds that expect to continue operating for any length of time should begin immediately

looking for supplemental or continuation funds. These "program operating" funds are usually of an ongoing nature and derive from federal or state service monies, e.g., Title XX (typically reimbursement for services, not necessarily operating funds), Title IV-B, Maternal and Child Health funds. National and local foundations, listed in "The Foundation Directory" issued by the Foundation Center in New York City, also have such monies. Local public programs, e.g., Revenue Sharing or LEAA programs, and local private groups such as a large community industry, auxiliaries, or United Way are yet other sources of funding.

Determining which of the possible programs, foundations and organizations should be approached for funds and developing the program plans and proposals most likely to receive favorable consideration can be a time-consuming, but obviously necessary endeavor. There are numerous publications, manuals, and information systems that catalog the public and private programs and foundation grants available and the requirements for funding. Some of these are prohibitively expensive to purchase (the grant information systems may run to $500 per year), but most are available for review at any large library or university. Other child abuse and neglect funding information may be available from sources such as the Federal Catalogue of Domestic Assistance. Additional sources of information related to program funding and proposal writing are listed in Appendix E.

One of the key points to remember when assessing the feasibility of funding is to be thorough but realistic, that is, be certain not to overlook possible funding sources, even if unusual, but do not waste time or resources approaching highly unlikely sources (no matter how worthwhile the project, a proposal for continuation funds will not be funded by a program whose express purpose is to provide start-up money). Another key point is the importance of considering both public and private funds. While public money is often necessary and desirable for start-up, a plan to insure continuation of funding and broadly-based support should be developed early in the project's life. Local funding is often easier to obtain in small communities with active community groups and organizations and large, single industries, while large urban areas may need to rely more on public funds, even though there is tremendous competition for these funds.

The final point is the importance of understanding the politics of the area, as well as the politics at the state and federal level. Developing a broad base of support should include the local political structure, the mayor's office or city council, and also the people and organizations who most influence the official policy of the area. Letters of support or actual testimony from these sources will often make the difference between the success or failure of receiving funding from <u>any</u> source. In general, seeking and obtaining funds from outside is not a substitute for community support and local financing -- the surest way to maintain a program.

Start-Up Problems

The start-up phase of a program, locating and outfitting facilities, hiring and training staff and readying the program for receiving clients, takes most new programs from three to six months. Expansion of an existing agency may require less time since facilities and some staff will already be available. There are a number of problems that almost all programs confront during this period.

First, it is very difficult to find prospective staff members with any experience working in child abuse and neglect. A well publicized job opening, given current economic conditions, will likely bring numerous applicants with good social service experience or promising educational backgrounds; however, they will be lacking specific experience or training in abuse or neglect. Programs have found that while such new staff members will require more initial training on issues about abuse and neglect than might be desired, with good training, the lack of specific experience seems to make little difference in the performance of staff or of the program.

Second, it has been difficult to find packaged training materials for new staff members. Such training materials are just now being completed by Urban & Rural Systems, Inc. in San Francisco; they will be tested and ready for general distribution during the coming year. The new program will have to search the existing literature, selecting books, articles and audio-visual materials which best suit the program's needs. This search can be time consuming, but educational in itself. Since no one method of staff training has been proven to be more effective than another, it is probably best for the training to be eclectic and as comprehensive as possible. In this respect, training is best thought of not only as a start-up activity, but as a continuing activity of any program.

Third, finding an appropriate facility for a program may pose great difficulties. Most often, program planners would like to find a space that is convenient to other key agencies and clients and provides a warm "home-like" setting rather than an official atmosphere. Zoning laws, licensing and other codes, prohibitive rents, landlord reluctance to rent to service programs, and the general unavailability of space make finding such a facility difficult. Perseverance is probably the key to finding a suitable location, coupled with the utilization of many different realtors, key contacts in the community, and even newspaper ads. It will be a rare program that finds and refurbishes space in a week or two.

Fourth, the actual translation of a program proposal into an operational program poses difficulties. Proposals are often overambitious and unrealistic given the actual resources made available to a program and the need to operate in the context of the existing community system. Problems are exacerbated if the Program Director was not among the proposal writers and if agencies with which the program must cooperate have

not been included in the development of the proposal. Excluding anyone who will be instrumental in implementing program activities from the initial planning can create difficulties in interpreting what the program is supposed to be doing and why, and can create resentment because of the initial exclusion. Program implementors should anticipate that plans will be modified to take into account the realities of resource availability and the ideas of those not included in the initial planning.

Management Problems

The management problems experienced by new child abuse and neglect programs fall into three categories: management of cases; management of staff; and management of resources, especially time.

The problem most often encountered in managing cases is the lack of case supervision; few programs provide for a staff member(s) whose primary responsibility is to monitor case handling. Even if supervisory staff are available, they often do not fully understand the nature of "case supervision." Without careful monitoring and review of what is happening to cases, clients drop out, do not get the services prescribed for them, or are kept in the caseload for an unnecessarily long time. Other issues related to case management are discussed in detail in Chapter VII.

The primary staff management problem experienced by child abuse and neglect programs is turnover or "burnout." Working with child abuse and neglect cases and working in a new program exact emotional and physical energy from staff. Assigning staff members diverse responsibilities, including training and coordination with other agencies, as well as treatment, and building time into the job for necessary rest and recuperation, can reduce these problems.

With regard to management of time, the issue confronted most frequently by new programs is avoiding spending too much time on general management and not enough on direct services. There is a tendency in new programs, particularly those which utilize collegial forms of decision making, to spend a great deal of time in staff meetings, reviewing procedures, planning activities and airing staff members' concerns. Such meetings are not only beneficial but essential. However, the program manager must take care to limit time spent in such sessions so that staff members have sufficient time to undertake direct services.

Problems Related to Service Delivery

It is not possible for a new program to anticipate every eventuality. Many of the details related to client services will need to be worked out after a program has started to accept clients into its caseload. However, there are some problems encountered by most new programs which the program manager can be aware of from the outset.

First, new programs, particularly those housed within private agencies, seem to have difficulty in establishing referral linkages. Agencies will be slow to refer cases to such new programs. Once they do start referring, however, many of the referrals will be inappropriate, and if unscheduled, the total number of referrals may overwhelm the new program. Thus, new programs should take care in identifying possible referral sources and in educating them about the program's capacity and the kinds of cases it plans to serve. A program may wish to implement its referral system in stages to avoid being overwhelmed with referrals before staff are ready to handle them. Initially, referral linkages could be worked out with the key public agencies in the community such as the law enforcement agencies, protective services, the local children's hospital and the schools. As cases are received from these sources, the treatment program could be implemented. Once the treatment program is operational, referrals could be sought from other agencies.

A second problem with which new programs struggle is defining the kinds of cases to accept. Even after the program has developed criteria for accepting cases, referrals will come in which do not fit those criteria but which the program will be inclined to accept for fear that these cases will not receive services elsewhere. Programs have two options: to take all cases, although this diverts energy from those cases earmarked for services, or, to attempt to utilize, or if necessary, develop services in other agencies where these cases can be referred.

Third, new programs often encounter problems in organizing the flow of clients through the program. Particularly troublesome are working out criteria for termination, determining if the criteria have been met, and actually terminating cases. It is often easier for a worker to hold onto a case than to declare that "we've done all we can" and suffer the separation anxiety of termination. However, if a program fails to terminate cases, caseloads will grow to unmanageable proportions unless intake is closed, and workers will be unable to effectively serve any clients.

Fourth, certain treatment services present more serious implementation difficulties than others. It is difficult to establish a system for handling emergencies which does not detract from other work and yet provides 24-hour coverage. It is hard to ensure that clients receive the prescribed services. It is not wise, at least for new cases, to leave this entirely up to clients; in many instances they simply will not hop on a bus or pay for a taxi themselves. It is difficult to provide multidisciplinary team reviews for every case in the program's caseload. While programs have found it relatively easy to bring together a multidisciplinary team (the main problems encountered have been debates over turf and issues of control), it is not easy for a team to do a thorough job on more than a few cases at a meeting. Thus, a program with a team will likely have to select only certain cases to send to the team. And, while many programs have little difficulty in obtaining some donated

services, such as consultants' time on a diagnostic team, other services, particularly expensive ones such as psychological testing of children, are very difficult to obtain in this way. Programs should simply not count on having expensive services donated.

Finally, and perhaps most importantly, most programs encounter great difficulty in reaching out to certain clients. Child abusers and neglectors are often initially very resistant to services and unable to accept help. For some cases in every project's caseload, this is going to be true. Repeated home visits, even though no one may answer the door, numerous phone calls and other attempts to make contact with prospective clients, coupled with early efforts to provide the client with concrete advocacy and support services, are essential to overcome this problem of resistance. Staff must learn to cope with their own frustrations in working with resistant cases in order to make the breakthroughs which help clients accept the necessary services.

Problems in Relating to the Community

No child abuse and neglect service program can exist in isolation from the rest of the community child welfare service system. But, there are many aspects of relating to the community system which cause problems for new programs.

First, new program staff members are generally anxious to spread the word about their activities. The desire to give talks, issue press releases and do radio and TV spots is great. There is, however, a potential pitfall in overemphasizing these activities too early in the implementation of the program; the program may be swamped with referrals and requests for services before it is ready to provide them. While it is necessary to inform agencies of the new program's activities from the outset, staff should wait until the program is ready to offer services before launching extensive publicity campaigns. Even then, community and professional education, particularly describing the program's activities, should be kept to a minimum until the program is well underway.

Second, many new programs experience difficulty in gaining acceptance from established agencies, especially if these agencies were not included in initial planning. It will take the new program some time to gain trust and respect from outsiders. This confidence will only come once the new program has demonstrated what it can do. If new programs promise more than can be delivered, if they do not follow through completely on referrals, and if they behave in contradiction to existing professional standards, the trust and respect may never come.

Third, not only do new programs encounter difficulties in establishing formal working "contracts" with other agencies, particularly the more established ones, but problems may also arise in putting those contracts into operation. Once another agency has formally agreed to work with

the new program, the onus will be on the new program to make sure that the agreement is brought to fruition.

Fourth, new programs, once underway, often find themselves inundated with requests for information, visits, and speeches. Because of the heightened interest in child abuse and neglect, and the general paucity of information, staff members of the new program are earmarked immediately as "experts" and numerous demands are placed on their time. There are ways to meet these demands without greatly interrupting program activities. A program can assign a particular day of the week as the time for visitors; speeches can be a responsibility shared by all staff members; and a program can produce a brochure about its activities to respond to most requests for information, reducing the need for individualized responses.

Finally, new programs will soon discover, if they did not during the planning stages, that there is a dearth of certain services in the community, notably day care, emergency shelter and foster care for children. While some programs choose to fill these service gaps themselves, others may wish to assist other agencies in filling the gaps so that comprehensive services can be provided to clients.

Some Comments

In the next chapter we discuss conducting a needs assessment, the basis for determining what kinds of services any new program should provide. Subsequent chapters discuss how to determine project goals, what models a program might adopt, what specific services a program might offer, how to keep track of clients and program resources, and how to relate to the rest of the community. The implementation problems discussed in this chapter should be kept in mind while planning and eventually implementing a child abuse and neglect service program.

CHAPTER III: NEEDS ASSESSMENT

Conducting a needs assessment to determine the treatment services, professional and community education endeavors, and coordination activities needed in a community is the obvious first step to developing an adequate service delivery system and should precede the development of all new programs. Often it does not happen; it is skipped or done casually. A needs assessment consists of the compilation and analysis of relevant statistical information as well as opinions, to determine needs in a particular area.

Although the problems most in need of correction often appear self-evident, many times these are merely the most visible ones, or those for which an acceptable and effective solution is already known. They may merely reflect problems that program planners want to see resolved (because of political pressure, bias, or previous experience) instead of the more important, underlying problems of the system with which they are working. A thorough needs assessment can help uncover some of these problems.

This chapter clarifies the reasons for conducting a needs assessment prior to implementing a new program, identifies the types of information that could be included in such an assessment, and outlines a method for conducting an assessment.

Purpose of a Needs Assessment

The reasons for undertaking a comprehensive needs assessment in planning for the initiation of new community efforts or the modification of existing programs are:

- to determine the adequacy of the current abuse/neglect service delivery system in part by identifying gaps in available services or duplication of efforts by different programs;
- to ensure that new or modified activites address community needs on a priority basis, i.e., solving the most important problems first;
- to ensure that plans are not made in a vacuum, in the absence of critical information which may later affect the implementation of the new program;

- to increase the coordination of the entire community system by involving other pertinent agencies and staffs early in the planning process and by developing a cooperative spirit among the participants;

- to provide information that might be used later as a baseline against which to evaluate the effectiveness of subsequent changes in the system.

Needs Assessment Methodologies

There are various methodologies for a needs assessment of a community child abuse and neglect system. Many have been developed for studying other social and health problems (see Appendix E for references), and the adaptation of existing methods can save time and error.

The following discussion provides guidelines for structuring a needs assessment that is useful at the community level. Although it may be made more appropriate to the individual requirements and situations of different communities, each step in the process is important and should not be overlooked. The steps in the process include: identifying all of the key agencies and individuals in the community; determining what information needs to be collected; obtaining copies of existing information; developing instruments for collecting additional needed information; collecting the data; analyzing the collected information and determining community needs; developing plans for periodic reassessment.

Step 1: Identify Key Agencies and Individuals: There are many agencies and programs in a community that deal with abused and neglected children or their parents. Many of these -- for example the Juvenile Court, the Protective Service agency, police, hospitals, child welfare and foster care agencies and schools -- should be involved in the planning and execution of the needs assessment. In addition to these agencies, there are many other agencies that should be included in an inventory of the community system. Agencies and persons providing child care, including day care agencies, Head Start programs, handicapped children's agencies, child guidance centers, Community Mental Health Centers, drug and alcohol abuse programs, public health nurses, private physicians, district attorneys, marriage and family counseling services, churches, and others, may see people with child abuse and neglect problems and should be included in the community inventory. Other community groups and individuals who are knowledgeable about child abuse and neglect and community services in general should be identified. These might include government officials, health and welfare planning agencies, civic group leaders, clergymen, funding agencies, and other private citizens involved with community problems. A group of former or current clients, whose perceptions about the adequacy of the system would be helpful, should also be identified. (It may not be possible to survey every agency and program in the initial needs assessment data-collection, but all of them

should be identified at this first stage in order to include them in the ongoing review of the community system.)

Step 2: Determine Information to be Collected: The determination of the information to be collected from each of the agencies and individuals identified above is a critical step. Participants in the assessment should identify, from the perspective of their particular agency, the critical issues in the system. The most useful information needed to assess these issues can then be determined by the group. The required information will normally include both quantitative data, for example "the number of abuse/neglect cases seen each year by agencies," and qualitative information, for example "the perception of clients regarding the quality of services they received." The information to be collected should be detailed and specific enough to highlight both strengths and weaknesses of the existing system and provide insight about possible solutions, but should not be so detailed that the assessment becomes an extensive research undertaking burdensome to all involved.

Table III-A provides a listing of the kinds of questions that should be answered by a thorough needs assessment. Some of the areas listed may be less important for some communities than others, and the collection of information required to answer them should be modified accordingly.

TABLE III-A: QUESTIONS TO BE ANSWERED IN A NEEDS ASSESSMENT

A. Community Demographic Information

1. What are the geographic boundaries of the community or service area (e.g., city, county, other)?

2. What is the population breakdown by age groups?

3. What are the basic socio-economic data by census tract or other small geographic area (e.g., income, employment, housing, family size, welfare assistance)?

4. What are the urban-rural characteristics of the community (e.g., population density, economic base)?

5. Are there concentrations of special populations (e.g., Indians, military personnel, ethnic groups)?

Table III-A (continued)

B. Community Resources Currently Available

1. How many agencies or individuals in the community system provide some service to abusive/neglectful families and who are they?*

2. What proportion of time is spent by these individuals specifically on abuse/neglect problems?

3. What functions do these individuals perform in the community system?

C. Comprehensiveness of Services Available

1. What preventive services are available to deal with child abuse/neglect (e.g., child management classes, pre-natal screening, family life education classes for teenagers)?

2. What outreach activities (e.g., maternity ward monitoring, presentations to high-risk groups) are there?

3. What community and professional education and training activities have been undertaken?

4. Is there a 24-hour reporting or crisis telephone line? If so, are staff on duty or on-call 24 hours a day?

5. Is there timely investigation of reports or complaints? By which agencies?

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* The following should be considered: Protective Services and other child welfare agencies; courts; police; schools/Head Start/day care; child guidance/development clinics; hospitals; clinics; private physicians; public health nurses; foster care placement agencies; public and private adoption agencies; community mental health centers; family/marriage counseling centers; drug/alcohol abuse programs; other public/private service programs; social service departments; community health planning agencies; and central fund raising agencies such as United Way.

Table III-A (continued)

6. What services are available and accessible for parents (e.g., individual and group counseling, lay therapist or Parent Aide support, couples counseling, Parents Anonymous groups)?

7. What services are available and accessible for children (e.g., psychological and other testing, day care, crisis nurseries, residential and foster care, child/play therapy)?

8. What services are available and accessible to families (e.g., crisis intervention, family counseling, housing, legal and welfare assistance, transportation)?

9. Are the following functions performed by agencies in the community: identification, investigation, treatment planning, treatment services, referral to other agencies, placement, follow-up?

D. Availability of Services

1. Approximately how many abuse/neglect clients receive the services listed in "C" above?

2. Are services provided in a format convenient for clients (e.g., hours of service, transportation provided if required, central location of services)?

3. Are services provided in a manner consistent with a "helping" or "therapeutic" philosophy, i.e., non-punitive and non-stigmatizing atmosphere?

4. Are services available in sufficient quantity to meet the needs of all the people requiring services? Are there long waiting lists, larger caseloads than desirable per worker, or restrictions on who can be served?

5. Are services well publicized?

6. Are clients aware that services are readily "available?"

Table III-A (continued)

E. Coordination and Functioning of Service System

1. What agencies should be coordinating efforts?

2. What methods exist to ensure coordination among agencies in matters of education, reporting of cases, treatment planning, legal activities, treatment, referral of cases and placement?

3. Is there a central agency in the community handling abuse and neglect?

4. Is there an inter-agency abuse/neglect task force or committee?

5. Is there a multidisciplinary team for evaluation and treatment planning?

6. Have procedures and agreements for coordination between agencies been developed?

7. Are there "gaps" in the system such that one or more of the functions is not being performed (e.g., referral between agencies does not occur)?

8. Is there duplication among agencies where two or more agencies perform the same function with respect to an individual client (e.g., two or more agencies investigate the same case)?

9. Are there points in the system where a client can be "lost" (e.g., a case is identified but never referred for treatment)?

10. If two or more agencies are providing services to the same client, is there a system for sharing information about the case?

11. Is there any central record keeping system in operation? What information is available from this system?

12. Are there any bottlenecks in the system (e.g., many more cases are reported than can be investigated)?

Table III-A (continued)

F. Effectiveness of the Service System

1. How many reports of abuse/neglect are received by all agencies in the community; is this number increasing? How does this number compare with national reporting rates or reporting rates for similar communities? What percent are repeat cases?

2. Is the number of reports from previously non-reporting sources increasing?

3. What proportion of reported cases receive an investigation?

4. What proportion of substantiated cases receive some services from community agencies?

5. How many abused/neglected children are removed from their homes? Returned home? How long does a child usually remain in foster care?

6. How many agencies perform some follow-up on the majority of their terminated cases?

7. What are the basic problems of the system as perceived by service providers?

8. What are the basic problems of the system as perceived by clients (or former clients)?

9. Are community residents and professionals aware of the problem of child abuse/neglect and the resources available to deal with it?

G. Costs of the Community System

1. What are the overall community expenditures for child abuse and neglect (including staff salaries, administrative support, promotional activities)?

2. What is the cost per client served?

3. What are the most and least costly services currently provided?

Table III-A (continued)

4. How do these cost figures compare with those of similar communities?

5. How do these cost figures compare with the amount of money spent on other social services in the community?

H. Funding Sources

1. What additional funding sources are available to the community (including public, private, federal, state, and local sources)?

2. What are the limitations on increased funds?

3. Are there non-monetary resources available (volunteers, civic groups, churches, other service providers) who could become involved with the child abuse/neglect problem?

Step 3: Obtain Copies of Existing Information: Some of the necessary information identified in Step 2 has already been compiled by various agencies and can be obtained from them. This includes copies of pertinent social service and health studies, census data about the community, state or local Central Registry reports (if one exists) and annual service and financial reports of key agencies. These data should be assembled and reviewed before the development of any new data collection methods. Even if the existing information is in a slightly different format from what is desired, or is somewhat out-of-date, it is preferable to use these data as is, and to concentrate on researching information that is currently unavailable from other sources.

Step 4: Develop Needed Data Collection Instruments: Based on the information needs established in Step 2 and with knowledge of what data already exists, data collection instruments should be constructed to obtain the additional information needed. These should be short, easy-to-understand materials that specify what information is desired. Individual questionnaires or checklists may be required for different agencies, depending on the functions the agencies perform and the knowledge that is available to them (for example, most data on "placements" will be available only from foster care agencies or the courts). Some questions, however, will probably be relevant for all agencies and individuals, e.g., "what do you consider the major problems in the child abuse and neglect system in this community?"

Step 5: Collect the Data: The actual data collection can take many forms. Interviews with representatives of key agencies may be used to gather information about the number of staff members working in the agency, the way in which they function with respect to child abuse and neglect cases, and their perceptions of the adequacy of the system. These personal interviews elicit more comprehensive and integrated information because they permit additional questioning about unclear statements, but some factual information may be collected through other means. Mail surveys often require a longer time for information to be received and may entail many calls or written reminders to agencies before they are completed and returned. Thus, in the interest of time, we would not recommend mail surveys. If the agency representatives surveyed do not have the desired "hard" data (e.g., service statistics) readily available, a viable means of data collection is to conduct a search of their records, or at least a sample of records, to collect the desired information. Clearly if such a record search is to be done, confidentiality of cases must carefully be preserved. In addition to individual interviews and record searches, a method of gathering information from many people quickly and easily is to schedule a meeting where the views of various people can be expressed on each issue. This is particularly useful for obtaining information from civic leaders, government officials, community residents and clients. Care should be taken to structure these meetings to ensure that the entire range of issues and questions is addressed and everyone has an opportunity to participate.

The whole conduct of the assessment can be concentrated into a short time-frame; it should probably not take much longer than a month for one person working close to full time.

Various guidelines and Standards have been issued which can be useful in measuring the adequacy or effectiveness of child protective programs, or in locating gaps and defining problems in the system. The Child Welfare League of America issued "Standards for Child Protective Service" in 1960 and revised them in 1973. In addition, The Children's Division of the American Humane Association published in 1955 "The Fundamentals of Child Protection: A Statement of Basic Concepts and Principles." Finally, the National Center on Child Abuse and Neglect will issue shortly a Federal Standards for Child Abuse and Neglect Programs in accordance with Public Law 93-247. There are also numberous studies on prevention, identification, and treatment that may be helpful. All these materials can assist program planners. But guidelines, standards, and studies cannot make a program. They can provide a frame of reference or a point of departure, which planners can use in light of their experience and the history of their agencies and communities. Planners must use their own judgement in adapting the knowledge and suggestions of others to the unique characteristics of their situation.

Step 6: Analyze the Information Collected: Once the required information has been collected, it must be analyzed by either the original planning group or, if no planning group has been established, by some group that represents various agencies, programs, and community groups. It is very likely that the information will be incomplete and some items will be of questionable validity. The different perceptions of agency representatives and conflicting data items will need to be reconciled, and interpretations as to the meaning of all the collected information will have to be made in light of other known facts about the community. Value judgements will be a necessary part of this type of analysis. As the information collected will demonstrate, different people will have varying opinions about what should be considered a "problem," and, consequently, it is necessary to include as many different viewpoints as possible in the analysis process in order to arrive at a consensus truly representative of community thinking about the problems in the system.

There are various problem-solving techniques that are often used with large groups of people to enable them to focus their attention on the pertinent issues and resolve their differences of opinion in a mutually satisfactory way. The Nominal Group Process, described in Chapter IV, which permits all group members to voice their opinions, to enter into directed discussion about various alternatives. and to develop a priority listing of concerns, is a useful method for this purpose.

Determining the adequacy of the child abuse and neglect system, or conversely, defining problem areas, would be facilitated immeasurably if generally accepted standards that delineate "adequacy" for various acti-

vities and services were available. While federal standards will be available soon, currently service providers and other community program representatives must rely heavily on their own experience and judgment to determine the adequacy of the system. They must consider the results of studies that have been conducted for different disciplines or programs, and the previous experiences of their own community or a similar one. This may be a more time consuming process than would be necessary if some standards were available, but it permits data analysis and problem delineation to be undertaken in light of the unique characteristics of each individual community.

Once the information gathered has been studied, problems or needs identified should be prioritized and analyzed, as discussed in Chapter I. Intervention points can then be identified, the most cost-effective solutions chosen and a plan for action developed. At this point, feedback should be provided to all Needs Assessment participants, including a summary of the information collected and the action plan(s) chosen. This step is often overlooked by those conducting needs assessments, and may engender negative feelings on the part of some individuals or agencies. No one should feel she/he has contributed to the study but never saw its outcome or participated in the decision making. Later coordination of the system could depend on the positive relationships developed during the needs assessment and subsequent planning process.

Step 7: Develop a Plan for Periodic Reassessment: A needs assessment is not a one-shot undertaking. It is necessary to re-evaluate the system periodically to determine whether the proposed solutions have been implemented, and if so, how successful they have been. It is also important to identify any new problems that have arisen since the last study. One method of accomplishing this is to initiate methods for ongoing collection of data on key indicators of the system's functioning from relevant agencies. These data can be analyzed to detect problems at any early stage. The identified problems can then be discussed by agency representatives and solutions developed. Only the most important information needed be collected routinely, but these data items should be tabulated continually by all pertinent agencies to provide a comprehensive picture of the community system.

If some elements of a thorough needs assessment were not undertaken in the original study (e.g., a survey of community residents' knowledge and attitudes about child abuse and neglect problems), plans can be developed for implementing these at a later date.

It may also be useful to develop a permanent community child abuse task force or council made up of the agency representatives who participated in the needs assessment. This group would have the ongoing responsibility for coordinating the community system and planning any new service components.

Some Cautions and Reminders

A needs assessment is often overlooked by those planning to implement a new child abuse/neglect project or program. This can result in the development of programs that do not respond to the real needs of the community, or that duplicate existing services, making the system less coordinated than before.

Although the needs assessment will take some time to develop, it should never be allowed to balloon into a great research endeavor. The prupose is to gather as much useful information as is needed in a short period of time. If the study drags on too long, the information will be out of date and much less useful for planning purposes, and enthusiasm for implementing a program may have waned. In order to prevent the needs assessment from becoming a costly, time-consuming study in itself, some compromises may need to be made. Where needed data do not exist, or exist only in case records that would need to be individually reviewed, inexpensive alternatives should be considered. For example, estimates made by agency staff might be sufficient or a sample of records could be reviewed to obtain estimates. Flexibility in the level of detail sought should be stressed. Other time and cost-saving measures include having volunteers or students conduct parts of the study, relying on already-developed survey instruments if possible, and gathering information from group meetings, rather than individual interviews.

Some community agencies may resist a needs assessment because they consider it threatening. It should be stressed that the purpose of the study is <u>not</u> to "evaluate" any agency's performance, but to help identify problems that <u>all</u> concerned can begin to solve. Early consultation with agencies, a sensitivity to the internal pressures of these agencies, a non-threatening approach by the study group and interviewers, and the provision of feedback to those who have participated should help to break down resistance to the needs assessment.

CHAPTER IV: PROGRAM GOALS

Following a community needs assessment, a program tailored to the specific requirements of the locale can begin. The first step in designing a new program should be using the information gathered in the needs assessment to define goals or targets for the program, selecting goals that seek to correct system inadequacies. After determining the direction the program's efforts will take, the other aspects of the service delivery package, such as treatment modalities, staffing patterns and budgeting, can be developed or refined. This chapter, then, explains what goals are, discusses the importance of clarifying goals and describes methods for identifying and measuring goals.

What are Goals?

There is a long-standing debate in the social sciences about the definitions of and differences between goals and objectives. Some people use the terms interchangeably while others differentiate between them. For the purpose of this discussion, "goals" are defined as those specific outcomes the program can realistically expect to achieve by the end of a particular time period. "Objectives," which specify types of activities to take place, are defined as individual steps along the way toward achieving program goals. Missions or "global goals" are those long-range outcomes that guide the total program along its chosen course. Our primary concern is with program goals and objectives. In order for goal statements to serve their function effectively, the following guidelines should be kept in mind.

First, goals should address both the community's and the clients' real needs. They should not serve the preferences of the program's staff, its Board or its administrative sponsor. This means that those involved in program management and determination of goals must be open to the opinions of a wide range of people, particularly as articulated through the needs assessment.

All of the aims of the program should be specified in goal statements. The list of goals should be realistically attainable given the size of the budget and staff. This will most certainly mean establishing priorities among a long list of possible goals, all of which may represent legitimate needs of the community.

A program should define goals that cover important components of a program package and avoid goals that are trivial or procedural. For

example, a goal of "setting up regular staff meetings" would generally be too narrow in focus to be considered an acceptable program goal.

Goals should be stated in clear terms so that everyone can readily understand what is to be achieved. It is difficult to determine the meaning of the following statement: "to utilize strategies for determining modalities for prevention of dysfunctioning in families which exhibit characteristics identified as possible causes for abuse." This idea could be more clearly stated in this manner: "to identify effective treatment services for potential child abusers."

Finally, goals should be stated in such a way that progress toward achieving them can be measured for evaluation and monitoring purposes. "To do well in delivering community services" is not an appropriate goal statement, because there is no measurable reference point for the word "well." Table IV-A at the end of this chapter illustrates some examples of goals for a child abuse program.

Importance of Identifying Goals

Formulating goals is important for at least three reasons. First, goals provide the program with direction. Because it is impossible to do everything, articulation of goals forces management to choose from competing demands and assists in determining whether resources are being allocated in accordance with the desired outcomes of the program. Second, goals make the intent of the program clear to the community. In most cases, the members of the staff, people in the community and in community agencies and the funding source(s) all have perceptions of what the program is supposed to be doing. The process of defining goals can make potential conflicts among the various interests apparent. Having a statement of goals can also provide the young program with a base from which to contend with the pressures of competing interests. Moreover, the process itself provides a method of identifying those individuals or agencies having differences of opinion so that program staff can work closely with them to reconcile the points of view. Finally, thinking and rethinking about goals and measures of those goals, during the lifetime of the program, provides a standard of performance against which evaluation can take place. Internal evaluation is critical if a program is interested in delivering services that are useful. Measuring goal achievement can and should be a primary concern of such an evaluation.

How to Select Program Goals

It is possible to select goals in several ways. An individual, such as the key program planner, can be responsible for determining the goals. He or she might attempt to do this alone, based on the knowledge of the community. While this is an efficient means to accomplish an end, it has some hazards, including bias, incomplete knowledge, and lack of later consensus. Of course, the person could elicit more information and suggestions for goals from the community by means of interviews with representative lay-persons and professionals. This gets the community involved but allows for no interaction and information sharing among the various community actors; consequently, a procedure for seeking consensus on goals is omitted. Furthermore, the biases of the interviewer can color the interpretations of insights collected from the interviewees. Choosing goals by means of a group of knowledgeable people, such as representatives of other community agencies, an Advisory Board if the program has one, potential or actual clients, or the staff as a whole, allows for a cross-section of ideas. However, holding free-form discussions has the disadvantage of allowing certain individuals to dominate, particularly people having high status or leadership positions. In addition, minority views are often unexpressed; energy is expended on competing for the floor instead of on listening to the ideas of others; discussions tend to digress from the issue; and in the end, the real decisions are hastily made.

Because of the advantages of decision-making in a group setting, a structured group technique, such as the Nominal Group Process, could be used to ensure a representative choice of goals and to assure agreement by a majority of people present. The Nominal Group Process was developed by Andre Delbecq and others over a ten-year period as they attempted to increase creativity and effectiveness in group idea generation for the purpose of planning and evaluation. It involves silent, individual effort in a group setting. The process as used for goal articulation begins by asking individuals in the group what they think the goals of the program should be. Each member of the group writes down his/her responses during a silent period of 10 to 15 minutes. This is followed by a round-robin discussion in which all ideas are shared with the group, deliberated upon, and then voted on, in terms of their importance or appropriateness. As a result, the group selects what it believes to be the best of many possible goals, while avoiding the pitfalls of unstructured group decision-making.*

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*In the Nominal Group Process, the silent period itself is tension-producing and, as such, idea-producing. It allows time to reflect and think. All members of the group participate. The method encourages the generation of minority ideas, avoids hidden agendas, makes each participant work and contribute, gives each a sense of responsibility for the group's success, fosters creativity as well as interaction,

Reassessment of Goals

Goals, at least in the beginning of a new program, should be flexible. Although a program should continually attempt to make progress in meeting its goals, in the first year issues will arise that can make the original goals unattainable. During the initial months, a program will confront the constraints of the "real world"; it may soon become clear that the agency cannot do as much as was hoped. The constraints of the budget, the skills and interests of the staff hired, and the realities of pursuing certain activities will call for goal reassessment. Therefore, it is to be expected that the program's emphases will shift during the first year of operation.

Because of the likelihood of changes in goals during the first year of operation, program management and staff should periodically rethink the program's direction and the feasibility of accomplishing certain goals. At the end of the first year, a structured reassessment should take place, again using a group technique such as the Nominal Group Process. This reclarification of direction will be essential for guiding the program toward accomplishing well thought out, feasible goals. As goals are met, or as experience changes expectations, goals can and should be reformulated throughout the life of a program.

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allows personal concerns to be aired, and is especially useful in a heterogeneous group since it does not permit any one person or point of view to dominate. Because the silent period is followed by the sharing of all ideas prior to their discussion, all members are assured that their ideas will be heard. In the discussion which follows, the benefits of group interaction, feedback and information-sharing are realized. Group members have a chance to question each other's ideas and clarify them. The group interchange is structured only by the time allotted for discussion and by the voting session, which gives each person another chance to express his or her views.

Not everyone endorses the Nominal Group Process approach. Some believe it is not as creative as it is purported to be and that it really does not encourage new ideas or innovative methods; others feel uncomfortable while using the technique or reserved about the outcome of the technique, in that it does not give dominant recognition to those having ultimate responsibility for program results or to those having the most knowledge and experience. In short, the technique treats all participants equally, rather than recognizing differences in expertise, levels of responsibility or accountability. Ultimately, of course, the results of such group work could be treated only as recommendations, awaiting final action by those having formal authority and responsibility for program actions. This may be done at the cost of some morale.

Measurement of Goals

One way for a program to evaluate its progress is to determine how well its goals are being met. In order to do so, indicators of goal attainment must be developed. Indicators are essentially clues about what the program is doing. Indicators for each goal should be determined at the beginning of program operation. They will clarify the implications of selecting particular goals, both in terms of work activities necessary to achieve the goals and in terms of the type of evaluation and monitoring required to carry out a goals assessment. The indicators should specify the data to be collected in order to know how well the goals are being carried out. Table IV-A shows the types of indicators that could be applied to the sample goal statement. Some reflect steps to be taken to accomplish the goals; others are outcomes that suggest goal achievement.

Because a goal achievement assessment should always be community and program specific, it is necessary to choose indicators that are particular to the locale and agency. While the program director or evaluator may be able to select the indicators, it is important to get input from both the staff and management who will have to be integrally involved in actually carrying out the steps necessary to accomplish the goals.

In a very small program, assessment of progress toward goals could be done on a part-time basis; however, in a larger agency it may be necessary to have a full-time evaluator whose task it would be to determine an evaluation design, develop instruments for collecting program data, and analyze the data.

TABLE IV-A: SAMPLE GOALS, OBJECTIVES AND INDICATORS

Program Goals	Objectives and Indicators
To increase the medical community's awareness of suspected abuse and the services available.	1) Participation of medical community in project's professional education programs. a. Number of meetings held with hospital physicians, nurses and social service staffs. b. Number of informational packets distributed to medical personnel. c. Number of courses/presentations given. 2) Inclusion of medical personnel in the program's activities. a. Number of medical personnel invited to sit on the Advisory Board. b. Number of medical personnel participating on the program's multidisciplinary review team. 3) Increase in referrals to the program from the medical community. a. The comparative proportion of all referrals to the program that come from the medical community in the years before and since the program's educational efforts began. 4) Awareness by the medical community of the abuse services available. a. Percentage of medical personnel who were contacted by the program that can correctly identify the services available.
To reduce the recurrence of abuse in the program's client families by developing a family treatment approach that includes an educational and therapeutic environment for both parents and children.	1) Implementation of the service components comprised in the treatment model. a. Types of services offered by the program for children or parents separately. b. Types of services offered by the program for working with the family as a unit. 2) Use of program services by families. a. Percentage of client families having more than one member receiving program services. b. Percentage of client families having both a parent and a child receiving program services.

TABLE IV-A: (continued)

Program Goals	Objectives and Indicators
	3) Improved behavior and attitudes of clients. a. Proportion of parents showing improvement in attitudes and behaviors related to abuse and neglect. b. Recurrence rate of abuse for clients in the families served.
	4) Improved family interaction of the clients. a. Percentage of families showing improvement in parent-child interaction. b. Percentage of families showing improvement in parent-parent interaction.
To identify the most effective treatments for abused and neglected children.	1) Designing a plan to assess the effectiveness of treatment strategies. a. Method for assessment of the child on entering the program. b. Selecting the control group. c. Procedures to reassess the child over time.
	2) Implementation of the design. a. Number of children assessed on entering the program. b. Completed records on the results of assessment and reassessment together with the amount and type of treatment provided.
	3) Awareness of the most effective strategies of treatment. a. Description of the treatments that proved most effective for those children in the program.
	4) Use of the results of the assessment/evaluation. a. Alteration of the program's treatment services as a result of the effectiveness study. b. Distribution of the results to others in the field.

CHAPTER V: PROGRAM MODELS

There are many different models of child abuse and neglect service programs. None has yet been shown convincingly, i.e., through systematic research, to be more or less effective than any others. The purpose of this chapter is to explore alternative organizational models and staffing patterns for child abuse and neglect service programs, and to describe prototypes for such programs. Clearly the kinds of programs developed in given communities will, in part, depend upon state and local laws and mandates under which organizations or agencies operate.

Program Dimensions

There are many areas in which programs can vary. These include: organizational context; source, type and amount of resources; program components; treatment strategies; staff, decision-making process; size; target population; location, and availability of services. Program planners should carefully consider each of these areas, some of which may be predetermined, as they design their programs.

(1) Organizational context: In what agency will the program be housed and with what other agencies will it be affiliated? The organizational context can greatly influence the nature of a program; the administrative structure can inhibit or enable successful execution of different activities. Programs may be in public or private agencies. Most communities have public protective services programs, as mandated by state law. In addition, programs have typically been housed in hospitals or private social services agencies. Other, equally viable, but less frequently used agencies include schools, Public Health Departments, day care centers, Juvenile Courts, or mental health centers. While most programs are housed within a single agency, a joint venture between two agencies is possible, although administration and coordination may be difficult.

(2) Resources: What will the resources of the program be? Where will the resources come from and will they be temporary or permanent? Currently, programs in the field have resources from a variety of federal, state and local governmental sources, private foundations and other private groups. Some programs make extensive use of volunteer services and receive a variety of donated items (including transportation and child care) as a way of bolstering their budgets. Some programs receive lump sums and others are reimbursed on the basis of individual services offered. Perhaps more important than the actual source of funds is

whether restrictions will be attached to the funding; whether the form of funding (lump sum, reimbursement) will present any cash flow problems; and how the amount of resources will restrict the program.

(3) Program components: What are the different activities the program intends to pursue? These activities, which should reflect the goals identified for the program, broadly include (a) direct treatment services for parents, (b) direct treatment services for children, (c) direct treatment services for families, (d) supportive and advisory services, (e) coordination of services for individual clients, (f) preventive activities, (g) professional and community education, (h) consultation and technical assistance for other professionals, (i) activities directed toward changing child abuse legislation and policy, and (j) coordination of the community child abuse and neglect system. Most, if not all, of any program's activities will fall into the above categories. For those programs pursuing more than one of the above activities, there are many possible mixes. Program planners should keep in mind that emphasis on any one activity will have implications, both positive and negative, for others. For example, staff members who spend most of their energy providing services to adult clients within the program may overlook problems of other agencies dealing with the same clients which could "undo" the benefits of treatment. At the same time, a strong emphasis on treatment may produce a staff that can effectively advise other professionals.

(4) Treatment strategies: Will treatment services be offered directly by the program or will the program be coordinating the delivery of services from other agencies? What kinds of treatment services will be offered? What stages of the treatment process will be emphasized? What theoretical orientation toward abuse and neglect will be used? The alternatives for treatment services, discussed in detail in Chapter VI, are many. The specific service to be offered should be determined only after a careful analysis of the options and the needs in the community.

(5) Staff: Will staff be professionally trained? What disciplines will be represented on the staff? Will staff primarily be paid or volunteer, full-time or part-time? Because of the nature of child abuse and neglect problems, many different skills and disciplines can work appropriately within these programs. Persons working in child abuse/neglect programs, either as treatment workers or in other ways, include social workers, community educators, teachers, lay therapist/parent aides (a lay person trained on the job to provide supportive services), logistic aides (lay person trained on the job to follow through with advisory services), homemakers, nurses, nurse practitioners, pediatricians, lawyers, psychologists, and psychiatrists. The selection depends on the specific services to be offered and the program's own philosophy about what skills are most essential. In addition to the positions listed above, some programs employ parents, who were previously abusers or neglectors, in the capacity of service providers. A program will at least want to have a director and coordinator, a bookkeeper/office manager

secretary, and some number of treatment workers including a casework supervisor. Not all programs use professionally trained caseworkers; some train lay persons on the job. The director may provide some services, but the number of other demands in running a program usually prohibits the director from handling as many cases as intensively as the treatment workers. Besides filling identified staff and consultant positions, a program should consider establishing (a) an advisory committee (which may or may not have decision-making authority, but which can help the program think through decisions and give the program leverage in the community); (b) a multidisciplinary review team (which may review cases at intake or periodically during treatment and which should truly be multidisciplinary, having at least three different disciplines, and preferably more, represented on it); and (c) a researcher or evaluator to document what the program is doing and to give the program feedback on its progress.

(6) Decision-making process: What will the chain of command be within the program and how will decisions be made? What feedback and communication methods will exist? Although the decision-making body will be determined in part by the agency within which the program is housed, there are many variations. Decision-making can be formal or informal, hierarchial, collegial or collaborative, participatory or non-participatory, centralized or diffuse. Observations of child abuse/neglect programs suggest that the particular form of decision-making adopted by a program will not greatly influence program effectiveness. What will influence the success of a program is how well the decision-making is carried out. What is important is that human needs are kept foremost, and that all participants feel their opinions are heard and valued.

(7) Size: How large will the program be, in terms of financial resources and number of clients? Although the actual number of dollars available to a program alone need not determine the scope of possible activities, the number of dollars coupled with human resources (paid staff and volunteers) will. The amount of funding does not strictly determine caseload size. If a program is planning to offer a very expensive service, such as residential care, the caseload size may be quite small in relation to the budget. Conversely, a program offering as its main service a relatively inexpensive one such as a 24-hour hotline may be able to serve many people, with limited resources. A program should probably plan on serving a minimum of 20-25 families at a time to be at all efficient. Although there are no guidelines for maximum caseload size, many people recommend that no one worker be responsible for more than 20-25 families.

(8) Target population: Who is the target population? Will the program work with all reported cases or only a limited number? Will potential as well as actual cases be served? Will both abuse and neglect cases be handled? Programs that are required or choose to serve all appropriate referred cases have substantially different problems from

those that serve only a select number of clients. In an unrestricted program, the caseloads will probably be much larger, the types of cases will be more varied, and the numbers of referrals may vary from month to month, requiring careful planning. Programs that choose to serve a select population must carefully define their selection criteria and inform potential referral sources of these. Criteria may be "first come, first served"; only abuse or only neglect cases; or select cases. Some programs choose cases with certain identifiable characteristics, such as living in a specified community, being free from drug abuse, or only single mothers. The types of clients one will accept obviously affect what services are needed and, thus, should influence what services will be offered. If a program cannot explain why its clients particularly need the kinds of services the program has chosen to offer, or why services which the program has decided not to deliver are of lower priority than services being delivered, there are legitimate grounds for suspecting that program planning and design has not been sensitive to the needs of the target population.

(9) Location: Will the program be housed in one location or several? To what other services will the program have proximity? What will the nature of the physical space be? Very few child abuse and neglect programs have chosen to operate from more than one office, although this may be beneficial in serving an expansive geographic area. Many programs, formally part of a public agency, have sought to locate in a separate building so that they can escape an office atmosphere and create a space more amenable to service delivery. Such a space often takes on the characteristics of a home, with lounging areas and the like. If a program has a choice of location, it should locate in an area accessible to public transportation and to other agencies.

(10) Availability of program: During what hours and on which days will services be available? Some programs are open only during daytime hours; others provide services throughout the day and into the evening, particularly for clients who work; still others are available 24 hours a day. Whether or not program staff are available to clients on a 24-hour basis, the clients will require 24-hour coverage since crises often occur after hours. Consequently, programs not providing 24-hour coverage for clients should arrange for this service to be provided by some other community agency. Delivering 24-hour coverage requires consideration of staff assignments, an overtime compensation policy and, most importantly, adequate management of the 24-hour coverage to avoid worker burnout.

Prototypes of Child Abuse and Neglect Service Programs

In this section, various models for child abuse and neglect service programs are discussed. The models selected are the ones that are most frequently used. It should be pointed out that some variation of the Protective Services Model presented here exists in every community, as mandated by state law.

Protective Services Model:. The Protective Services unit of the public social services agency in most communities has been a primary provider of services for abusive and neglectful families. Traditionally, Protective Service units have offered counseling and advocacy services to clients, provided by professionally trained social workers. Recently, some Protective Service departments have revamped their programs. Staffs have been expanded to include homemakers, nurses, psychotherapists, and lawyers. With the additional skills represented by these disciplines, plus an emphasis on purchasing or contracting for services from other agencies, more and varied services are offered, although counseling and advocacy services remain primary. Such programs still handle all reported cases of abuse and neglect in the community; however, caseload sizes for individual workers have been reduced, allowing for more intensive, as well as more varied, service offerings.

This model has several advantages. First, the agency is legally mandated to investigate and treat abuse and neglect cases, and thus begins with legitimacy, authority and credibility in the community. Second, the agency has a permanent source of funds. There are also several disadvantages. First, the program must abide by civil service rules and regulations, which can be somewhat restrictive, although there are benefits to such rules. Second, the program must compete within the agency for money, attention and control. And, finally, clients are often resistant to receiving services if they are provided under the auspices of the "Welfare Department," which often has formal linkages with law enforcement agencies.

A variation of the Protective Services model is to have two units within the program, one focusing on intake/investigation and the other on treatment. The benefits of this approach are that the investigation and diagnosis can be much more thorough; the investigation worker, who bears a certain stigma in the client's mind, is separate from the treatment worker; and the treatment can be more directed, since treatment workers do not also have to concentrate on intake. However, there are some very real problems with this approach. First, the chances of the intake workers burning out are great. Intake/investigation in many ways is the most exhausting phase of treatment and these workers never have a chance to relate to any clients for an extended period of time; this often denies them the positive aspects of working with abusive and neglectful parents. Second, unless a very smooth transition is worked out between the intake and treatment units, treatment workers may have to repeat many of the intake investigative steps to make sure that they understand the case and that clients receive the services they need. Finally, the client may suffer by having to establish a rapport with more than one worker.

Hospital Model: Some hospitals, primarily children's hospitals, have initiated or sponsored child abuse and neglect programs. These programs, typically linked with the hospital's social service department, focus on identifying and diagnosing cases. They provide special

training for all hospital staff, particularly doctors and nurses who work in the emergency room and outpatient department. The program staff is on-call to assist in diagnosing suspected cases, reporting the case to the appropriate agencies and coordinating treatment services for families with other agencies in the community. A trauma team, composed of program and hospital staff, is typically included in the diagnosis of the most severe cases, if not for all of the cases. A few programs also provide their own treatment services, including group therapy and child care.

The hospital model has a number of advantages. The program has financial support from the hospital and access to hospital services, particularly medical care for the abused or neglected child and parents. The credibility of the hospital gives the program important leverage in the community, while also ensuring some physician participation. The physician can be of great value as a consultant, without carrying the full burden of the management of cases. However, in such a program the medical viewpoint can prevail, with the emphasis exclusively on diagnosis to the detriment of treatment, and social workers and others may be forced to take a back seat to the doctors. The focus of the program will likely be on physical abuse. Additionally, a hospital can easily become isolated from the community it serves unless it maintains communication with the local protective services agency and others.

Private Service Agency Model: The private service agency model is most often a small center, with a small caseload of 20-40 families, offering treatment services on the premises (usually including group therapy, individual counseling, 24-hour hotline counseling, and often day care as well). Therefore, the focus is on the family as a unit and the program facility is selected and decorated to reflect more of a home-like than office atmosphere. These programs are very selective in identifying and accepting cases.

The benefits of such a program are the relative lack of red tape, flexibility in meeting clients' needs, and minimization of stigma for clients, maintaining client anonymity when necessary. The disadvantages are that the program will initially lack legitimacy in the community and may have difficulty securing interagency linkages; funding is usually unstable and may make it difficult to retain highly skilled staff on a long term basis.

Two distinct variations of this model are: (1) a residential program and (2) a program that concentrates more on education and coordination than on direct services.

Volunteer Model: There have been several programs that operate almost exclusively through volunteers. The volunteers may or may not include former child abusers and neglectors. These programs are primarily concerned with treatment, although large numbers of requests come

to them for training and education. Three services commonly offered include: lay therapy or parent aide counseling (lay persons, trained on the job, assigned to 1-3 families to provide friendship and support); Parents Anonymous (small therapy groups run by and for abusive or neglectful parents); and 24-hour hotline counseling. Operating with small budgets and, occasionally, a paid director, these programs typically operate independently from other agencies in the community. As such, they are bound only by their own rules and policies. Often they can more easily offer services to clients that reflect the clients' expressed needs in a non-stigmatizing way. The unit cost of services is substantially lower than other programs and clients find it quite easy to relate to the "non-professional" service provided. While volunteers may be the most enthusiastic of workers, the turnover rate is likely to be higher than that of paid staff. A second drawback is that volunteers, by virtue of their lack of training, may be unable to diagnose cases of abuse or neglect or are unprepared to work with the most severe cases of abuse or neglect. When the primarily volunteer staff is supplemented with a professional casework supervisor, this problem can be eliminated.

Coordination Model: Some agencies, primarily public but in some instances private, have adopted a coordination model. With such a model, the agency takes primary case management responsibility for clients, but services are provided, often on a purchase-of-service basis, by other agencies within the community. With such an arrangement, the agency staff have more time to generate service providers in the community and to ensure that clients are handled efficiently and effectively. A variation of this model is for the agency to additionally relinquish the case management functions and to devote all of its time to developing a more coordinated set of services in the community.

CHAPTER VI: TREATMENT STRATEGIES FOR PROGRAMS

There are many different services that might be appropriate for abusive and neglectful parents and their families. At present, there is little empirical data on which treatment services are most effective for different people. There are also many different schools of thought about the causes of abuse and neglect and the most appropriate treatments.

First, there are those who take a criminal justice approach, arguing that parents who abuse or neglect should be prosecuted, and minimally the child should be protected by removal from the home into foster care.

In contrast to this once prevalent and now diminishing approach, others argue for trying to keep the family together, while providing treatment services. There are those who take a psychiatric approach, explaining abusive and neglectful behavior as a result of internal conflicts, low self-esteem, and other weaknesses of the parent. Psychotherapy, most often individual rather than group, is advocated by this school.

Others discuss abuse and neglect in terms of a socio-economic model in which behavior is explained by environmental circumstances. The stress of poverty and other social problems is seen as a primary cause of child maltreatment. Individual counseling and advocacy and supportive services that help break the poverty cycle are advocated both for parents and their families.

The group dynamics approach attributes the abuse or neglect problem to the breakdown of the extended family and increased feelings of alienation and isolation experienced by many people in modern society, particularly those in urban areas. The suggested intervention is to provide people to talk to and to lean on -- Parents Anonymous, group therapy, other forms of group activity, lay therapy counseling or foster grandparents. Family-oriented treatment including day care is also advocated.

Those taking an anthropological approach base their arguments on the premise that certain racial and ethnic groups have traditional socialization patterns that include forms of discipline that outsiders might regard as harsh, abusive or unnecessary. This approach stresses that the intervention, which may be one of many forms of therapy, must be tailored to the characteristics of the particular ethnic or racial group in question. Treatment according to this approach should help

parents understand the reasonable limits of their culturally-based forms for discipline, instead of attempting to eliminate the discipline.

Finally, the educational approach suggests that the parents lack an understanding of child development, nutrition, health care, or homemaking skills that are causally related to abuse and neglect. Homemaking, parent education, and child management classes are advocated.

Overall, the focus of these different schools of thought, and the literature in general, is on the abusive or neglectful parent, and what his or her needs are, rather than on the child who is maltreated.

It may be that each of these approaches is germane to understanding the dynamics of abuse and neglect for some kinds of families or situations. Abusive and neglectful behaviors are not simple phenomena. Nor, despite the similarities in outcome (e.g., a bruise, a broken bone, etc.) are the behaviors explicable by a universal theory covering all abusers and neglectors. There is much to take into account in understanding abusive and neglectful behavior and the most appropriate approaches to services. Therefore, we do not advocate any particular approach. Rather, the purpose of this chapter is to identify the range of treatments that a program might offer to parents, children and families, and to suggest some of the critical issues to consider in planning for these services.

Dimensions of Services

The mixes of treatment services offered vary greatly from program to program. This variation reflects not only the differing orientation of program staffs toward the abuse and neglect problem, but also the different objectives of programs, the kinds of agencies in which programs are housed, the kinds of clients the program intends to serve, the skills of the staff, the program's resources and the needs of the community. A program should address the following questions, which are similar to those addressed in selecting a program model, in planning its own treatment service options.

- Will the program take primary responsibility for management of the case, or just provide services for cases being managed by another agency?
- Will the program be housed in a public or private agency? How will this influence the kinds of clients to receive services and the services that will be offered?
- Will the program be housed in an educational, medical, legal, social service, mental health, public health, or other type of agency? How will this influence treatment offerings?

- Will the program provide services to all appropriately referred cases or to just a limited number of cases?
- Will the program provide services for whole families, only adults, or only children?
- Will the program treat preventive as well as actual cases?
- Will the program treat physical abuse, emotional abuse, sexual abuse, physical neglect, emotional neglect, medical neglect, or combinations of these?
- What other criteria will the program use to decide who will receive services?
- Will the treatment be short (3-6 months) or long (1-2 years)?
- What kinds of staff members will the program have: professional, lay, paid, volunteer, a mix?
- What resources will the program have: large or small budget, lots of space or no space, cars?

Treatment Options

The variety of treatment options for a program are presented below. Each option is treated as a distinct service. However, the benefits of one type of service often occur in conjunction with another. For example, individual counseling can be given while a worker is transporting a client. In practice, services are most often offered in combinations. The listing below is certainly not exhaustive; it reflects what many child abuse and neglect programs are currently offering. The services fall into four main categories: supportive and advocacy services; treatment services for adults; treatment services for children; and treatment services for families. A fifth type of service, in the form of client participation, is also presented.

Supportive and Advocacy Services: Supportive and advocacy services are most often important in gaining the client's trust at the beginning of treatment and may also be the basis of services throughout treatment. They can be directed at a number of the client's situational problems, such as lack of food or poor housing. In order to promote effective delivery of these services, the program must develop expertise in how other agencies in the community function (e.g., the juvenile court, the welfare department, the housing department) and must establish a good working relationship with key staff members in those agencies. In this way the program helps assure that clients get needed services from other

agencies with whom the client may be at a disadvantage. At the same time, it helps those agencies become more responsive to the needs of abusive and neglectful clients. Advocacy services may include the following:

- INCOME AND EMPLOYMENT ASSISTANCE: Activities here vary from helping a client to obtain welfare, enroll in job training, vocational rehabilitation or education that will lead to job improvement, or helping a client with money management within the home.

- HOUSING ASSISTANCE: The worker may assist the client in securing better housing or in making his/her present dwelling more livable.

- HEALTH AND WELL-BEING ASSISTANCE: Medical, dental or optometric care, family planning counseling, or homemaking services that furnish instructional assistance in nutritional, hygienic and other health-related matters may be provided.

- LEGAL ASSISTANCE: Here, workers may pave the way for clients to deal with the courts or police on a variety of legal problems.

In addition to these advocacy services, supportive services such as the following may be offered:

- TRANSPORTATION: The client may be provided with transportation to and from service appointments, and for other daily activities such as shopping.

- CHILD CARE: Workers may arrange for child care for the client's children or may even babysit, giving the client free time to participate in services or for other daily needs. Child care can also provide a respite from the demands of child-rearing, often reducing the stress associated with child abuse and neglect.

- WAITING WITH CLIENT: A worker may sit with a client while he/she waits for a doctor's appointment, a court hearing, or other services, and at that time assist the client with procedures, as well as providing support.

- HOMEMAKING: A client may receive assistance with cleaning, meal planning, cooking and the like, thereby alleviating certain household stresses and pressures.

- EMERGENCY FUNDS: Small allotments of money may be given to clients to reduce the stress of financial crisis.

Treatment Services for Adults: The general focus of these services is providing the client an opportunity to work through particular behavioral, situational, or attitudinal problems in settings that foster support and friendship. The variations among them depend on whether the service is for an individual or a group, the degree of formality of the service, and the range of skills required of the service provider. These services include:

- INDIVIDUAL COUNSELING: Individual counseling includes a range of one-to-one interventions aimed at improving the social behavior and situation of the client. Usually the counseling involves discussions between the worker and the client about the client's situation and problems and the possibility of change or improvement. Advocacy and supportive services are often used as back-up for this counseling. The counseling may be broadly based, touching on a number of social, psychological, or economic issues, or focused on specific issues, such as the child abuse or neglect situation.

- INDIVIDUAL THERAPY: Individual therapy is distinct from individual counseling in that it is more structured, requires a different set of skills from the service provider, and tends to be more focused. The therapist, most often a trained psychologist, psychiatrist, or social worker, meets with the client, usually for one-hour sessions once or twice a week, and, using a psychological or social-psychological orientation, helps the client better understand his or her problems. Such a service requires a receptivity on the part of the client and a commitment to work on his or her problems.

- PARENT AIDE OR LAY THERAPIST COUNSELING: Counseling provided for clients by lay persons is a relatively new, very economical, and exciting approach to services. A lay person, typically a volunteer who is trained on the job, is matched with a client (on occasion, two or three clients) to provide support, empathy, and friendship to that person. This special counselor visits with the client, helps with household and other responsibilities and generally provides the client with someone to share concerns. The success of such treatment lies in the selection and training of appropriate persons to do the counseling, and the support and supervision given to them on a continuing basis.

- COUPLES COUNSELING: Often the problems experienced by a client are directly related to relations with a spouse or mate, indicating a need for couples counseling. Akin to individual counseling in terms of the support provided, the counselor meets with married couples or two adults living together to help them talk through their difficulties with each other and their children.

- GROUP THERAPY: Group therapy, a widely used approach to treatment, is a series of meetings, run by a skilled leader, for about 6-10 clients. Through the use of a variety of group techniques, clients talk over and, ideally, begin to come to terms with their problems. The sessions tend to be open-ended, dealing with a wide variety of issues, although more structured techniques, such as Transactional Analysis of Gestalt Therapy, may be employed. Group therapy can help the client understand that his problem is not unique, but is shared by others, and concurrently gives the client an opportunity to develop social bonds. In some cases, group therapy is used to focus on problems of special groups, such as alcoholics or drug abusers.

- CHILD MANAGEMENT OR PARENT EDUCATION CLASSES: Child management or parent education classes, which may have nothing more in common with "classroom courses" than the fact that they meet at specified intervals, are a series of group sessions devoted to child development, parenting and family relations. A detailed curriculum may or may not be specified in advance; discussions may or may not replace a lecture format; children may or may not be included. The most common format used in child abuse/neglect programs is a directed but informal approach in which small groups of parents try to learn new positive behaviors, mostly from their own experiences and those of others in the group. Programs have found it beneficial to have someone knowledgeable about parent-child relations and child development lead such a group, and to have parents occasionally bring their children for more direct learning experience.

- 24-HOUR HOTLINE COUNSELING: Many programs have a telephone line that a client can call at any time, day or night, to reach out for help and receive therapeutic assistance, or at least be assured of reaching a patient listener. Calls may be limited to the program's identified client group, or may be open to anyone in need; calls may or may not be anonymous. A smoothly operating hotline requires careful planning and in most cases participation by most, if not all, of the treatment staff. Staff members having hotline duties are given special tutoring in listening skills.

- CRISIS INTERVENTION: Crisis intervention, which implies emergency, non-scheduled meetings with a client at times when the client is in crisis, may overlap in content, although not in concept, with many of the above-mentioned services. A worker may be providing regular counseling or therapy to a client during office hours, but crisis intervention requires the worker additionally be on-call and capable of intervening, day or night, whenever the client is in need. As such, crisis

intervention requires careful planning to provide 24-hour coverage, if desired, without disrupting workers' other responsibilities to clients. Crisis intervention for adults may be provided in the context of a community's Comprehensive Emergency Services 24-Hour System.*

Treatment Services for Children: Historically, treatment services in the child abuse/neglect field have been directed to the adult. With the exception of FOSTER HOME PLACEMENTS and MEDICAL SERVICES, both of which are essential in certain situations, the child has been overlooked. In an effort to help the child overcome some of the residual effects of abuse or neglect, and to reduce the likelihood that the child will become an abusive or neglecting parent, programs are increasingly developing specific treatment services for the child to complement or be used instead of foster care and medical care. In many instances, these services are beneficial to the parent as well. Included among these services for children are the following:

- THERAPEUTIC DAY CARE/CHILD DEVELOPMENT SESSIONS: A therapeutic day care program, called child development by some programs, is typically provided five days a week for 4-8 hours a day. In addition to supervised care for the child during the daytime, special activities to deal with the child's developmental, psychological, and emotional or motor problems are provided. This therapeutic approach to day care allows for individualized treatment for children in a group setting. Like day care in general, programs providing therapeutic day care must ensure not only that licensing and other relevant regulations are met, but that the necessary supervision, space, equipment, toys and supplies are available.

- DAY CARE: The basic day care program is oriented toward providing the child with organized play and other activities during the day in a group setting. The emphasis is less on the needs of individual children, and more on providing all children with a safe, enriching environment.

- CRISIS INTERVENTION: Crisis intervention, which implies emergency, non-scheduled interactions with a child, may include the provision of services to the child in the home or, if

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* The Comprehensive Emergency Services 24-Hour System, developed in Nashville, Tennessee, is a program which involves a coordinated, comprehensive child welfare service provided on a 24-hour basis, extended to families to prevent unnecessary separation of children from their families during crisis. Materials describing this system in detail are listed in the bibliography.

necessary, by removing the child from the home at any time of day or night. Such intervention may be provided in the context of a community's Comprehensive Emergency Services 24-Hour System.

- CRISIS NURSERY: A crisis nursery is a place to which a child may be brought at any time, day or night, and left for short periods of time when a parent is undergoing a crisis or simply feels in danger of taking out frustrations on the child. The nursery itself may be in a home or on a program's premises. Careful attention must be given to ensuring that the nursery actually provides 24-hour coverage. One danger in operating a crisis nursery is that it may be used as a long-term placement center rather than as temporary care for the child.

- RESIDENTIAL CARE: Residential care implies longer-term, non-emergency day and night care of children, providing a warm and reinforcing living environment. Therapeutically oriented services for individual children may be included in this treatment, and parents may be involved in daytime activities of the residential center. Because of the 24-hour nature of the care, the requirements for a workable center, including staff, facilities and materials, are much more extensive than those of a day care program.

- INDIVIDUAL THERAPY: The types of individual therapy provided to a child depend very much on his or her age and needs. Play therapy, using play equipment to promote the child's self-expression, and individual therapy, one-to-one counseling by a child psychologist, psychiatrist, or other trained worker, are more often appropriate once a child has reached pre-school age. Other forms of specialized therapy, such as speech or physical therapy, may commence at an earlier age.

Treatment Services to Families: Besides supportive and advocacy services, which tend to benefit the whole family, and the range of crisis intervention services provided under a Comprehensive Emergency Services 24-Hour System, very few programs provide treatment services for the family as a unit. Such treatment services are, perhaps, more difficult, both logistically and because the individual problems are compounded in this setting. However, the benefits are probably as great as for individualized services. Examples of family services include the following:

- RESIDENTIAL CARE: Some programs provide residential care for both parents and their children. Such care is usually temporary (two weeks to three months). Many of the other treatment services for adults and children are provided within the residential setting. Like residential care for children, such care is very expensive and requires extensive planning and monitoring.

- FAMILY COUNSELING OR THERAPY: Like couples counseling, family counseling may be provided for most or all members of a family when the relationships and dynamics among them are a problem. At times, the counseling may be provided for individual family members and at times for the family as a group.

Client Participation: Clients are often the victims of an isolated and alienating life. While services such as group therapy help to create situations in which clients can form bonds with other people, client participation in various activities is a more direct approach to helping the clients reduce their alienation and possibly enhance their self-esteem. Examples of these include:

- PARENTS ANONYMOUS: Parents Anonymous, which is similar to group therapy, is a series of group sessions complemented by other activities, run by and for abusive or neglectful parents. Although such groups ideally have one or two resource persons who act as sponsors and attend the group meetings, Parents Anonymous is very clearly oriented toward having the parents organize and help themselves.

- PARENT CONSULTANTS: Some programs use "rehabilitated" clients as treatment workers. Such parent consultants provide important and often overlooked perspectives on the needs of clients, while benefiting themselves from direct involvement in service delivery.

- CHILD ABUSE/NEGLECT COUNCILS OR OTHER ORGANIZED CHILD ABUSE/NEGLECT ACTIVITIES: Many communities are now developing child abuse/neglect councils or child abuse/neglect activities such as Speakers Bureaus or legislation committees. Encouraging clients to participate in such groups can be therapeutic for both the client and the group members. Participation may include actually helping to organize and manage the group's activities, giving speeches, or helping to operate a hotline.

Examples of Treatment Program Mixes

There are many possible combinations of services that would result in viable programs. It may be true that certain services cluster more naturally than others (play therapy can easily be incorporated into a day care program; certain advocacy services follow naturally from individual counseling), but this should not negate a program's desire to test innovative mixes. As mentioned, little is currently known about which services are most effective for given clients. Therefore, it is to the field's advantage for programs to try new strategies and to assess how well they work. To give the program planner a feel for the mixes that are possible, the following examples describe five programs that use mixes of services in very different ways.

Program A is an independent center, providing services on a daily basis to families referred by various local agencies. Group therapy and individual counseling are provided weekly for parents and the Center operates a 24-hour hotline for its clients. Two day care programs are operated for children; one for infants and one for pre-schoolers. The pre-school program focuses on the specialized problems of the child. Parent consultants are included as part of the treatment staff, and a Parent Advisory Board, composed of interested adult clients, has input into major program decisions.

Program B serves only adult clients referred to them by the local Protective Services Unit, which maintains primary responsibility for the management of the case. Clients attend child management classes or group therapy sessions, or both, on a weekly basis, and may receive the supportive services of a parent aide or lay therapist.

Program C is housed within a Protective Services Department. This special child abuse unit provides adults with individual counseling, complemented by advocacy services, particularly those related to income and housing. Clients' children who have not been placed in foster homes are referred to day care programs whenever possible.

Program D is a residential facility for parents and children. Parents are helped with homemaking skills -- meal planning, cooking, money management -- as well as provided individual and group therapy. Workers provide direct assistance to mothers in caring for their children, particularly around meal time. The program, affiliated with a hospital, provides comprehensive medical services for the entire family. Families stay in the residential facility for three months, after which time they receive services on an "outpatient" basis.

Program E offers as its primary service 24-hour hotline counseling. Anyone may call the program, anonymously or not, and receive support. When necessary, home visits, advocacy and respite care for children are also provided by this program, which is staffed primarily by volunteers.

Some Comments and Cautions

Most clients go through a series of stages during treatment. To some extent, these stages dictate what services can most effectively be offered to the client. Initially, and for some time after intake and diagnosis, the client is probably in the most resistant phase. Supportive and advocacy services are most successful at this stage, since the client is not likely to be ready to accept more therapeutic services. Concrete actions on the part of the service provider that directly affect the client's life, such as help in finding new housing or a day care center, go a long way not only toward improving the client's life, but also in developing the client's responsiveness to other services. Once the client is interested in the program, more therapeutically or

educationally oriented services, either individually or in groups, are appropriate. During this receptive phase, the client should be prepared for the final phase of the treatment process, termination. Termination, which means the reduction or cessation of services to the client, can be the most traumatic phase unless the client is prepared well in advance. Preparation includes reducing the dependence of the client on the service provider(s) and services.

It is not easy to implement any treatment program. Regardless of the amount of careful planning prior to the initiation of service delivery, unanticipated problems and situations will arise once services commence. Thus, a hasty change of plans when initial problems occur should be avoided. Once a set of treatment services has been decided upon, it would be well to work with the mix for some time (six months to a year) before deciding that the mix is inappropriate.

CHAPTER VII: CASE MANAGEMENT

Case management is that broad range of activities required for coordination of services to a client and for monitoring client progress. Case management includes all phases of contact with a client: outreach, intake and initial diagnosis, development of treatment plans, arranging for client's receipt of services, monitoring client's receipt of services and the client's progress, revision of treatment plans, and arrangements for termination and follow-up. Good case management allows for the planful handling of cases, resulting in more effective services for the client and more efficient use of program resources. The purpose of this chapter is to identify the essential elements of case management, the kinds of information that should be maintained on individual cases and the ways that information can be used for effective case management.

Essential Elements of Case Management

This section lists questions related to those elements of case management considered essential by many people working in abuse/neglect programs. The questions provide program planners, management and staff with a basic checklist that can help them determine whether individual cases are progressing satisfactorily and whether the program's case management component is operating properly and effectively.

In general, the gauges, or standards for measuring the performance of these elements, have not been specified. (For example, the list includes, "Are the program's criteria for case acceptance adhered to?" without specifying the appropriate criteria for a given program, and, "Is the time that elapses (the interval) between the initial report and the first contact minimized?" without specifying how much time should or should not elapse.) Each program will have to determine for itself the appropriate standards or gauges for these elements.

Intake: The first contacts with a client are important because they set the tone for what is to follow. During intake, a careful balance between investigative and supportive activities must be effected. Essential questions of case management for intake include:

(1) Does the program have criteria for determining which cases to accept?

(2) Are the criteria for case acceptance adhered to?

(3) Is the time between initial report and first contact minimized?

(4) Is the investigation process coordinated both within the program and with other agencies involved with the case?

(5) Is there a sufficient amount of contact with the client, other household members and other agencies prior to the completion of intake and diagnosis?

(6) Is a helping philosophy (one that indicates a supportive rather than punitive approach) communicated to the client during intake?

(7) Is it made clear to the clients what the program is going to do for/to them?

Diagnosis/Prescription of Services: Once a case has gone through initial intake, it is necessary to identify the client's problems, to assess his or her needs, and to determine the most appropriate services. To do so, workers must obtain many different kinds of information about the client and his or her family. Essential questions of case management during diagnosis and prescription of services include:

(1) Has the necessary background information on the client and his/her family been obtained, including:

- story of the abuse/neglect incident and surrounding circumstances* from each of the parents' perspectives and, if possible, from the child's perspective;
- basic demographic, socio-economic information on the family;
- childhood experiences of both parents;
- description of family stress factors and conditions;
- evaluation of parent-child interactions;

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* This report should be concerned with what is going on in the family rather than which individual is most responsible.

- assessment of parents on critical characteristics related to abuse/neglect such as extent of isolation, awareness of child development, self-esteem, reactions to crisis situations;
- identification of key people in family's life;
- identification of other agencies involved in the case;
- measures of child's physical, emotional, psychological and social development?

(2) Have feasible treatment goals been established, i.e., realistic, measurable, non-ambiguous outcome statements? When were they established?

(3) Has a treatment plan that specifies the services to be offered, as well as who will provide them, been developed?

(4) Is the case to be reviewed by a multidisciplinary team?

(5) Have the waiting lists for services and, consequently, the waiting time for services, been reduced?

(6) Is the time between the first contact with the client and the initiation of treatment services minimized?

Treatment Process: During the provision of treatment services to a client, program personnel should be aware of the amount and types of services the client is receiving, both from the program and from other community agencies. This information, coupled with observations of client progress, will enable revision of treatment plans as necessary, and more effective judgments regarding discontinuation of services. The essential questions of case management during the treatment process are as follows:

(1) Does the program have standards for the minimum frequency of contact with clients?

(2) Is the frequency of contact with the client and other members of the family checked?

(3) Are the program's minimum contact standards met?

(4) Does the program persevere with resistant cases, i.e., clients who initially or continually resist contact with the program?*

(5) Is the client's use of services monitored?

(6) Does the program have criteria for the format and timing of case review?

(7) Are the criteria for case reviews met?

(8) Does the program have criteria for the maximum caseload size per staff member?

(9) Are the caseload size criteria met?

(10) When clients are referred to other agencies for services, are the referrals followed up to ensure that contact is made?

(11) Is the client's frequency of contact and progress with agencies to whom he/she has been referred monitored?

(12) Are other agencies working with the case, particularly the referral agency, kept up to date by the program on the client's progress?

Termination/Stabilization: Although all programs do not formally terminate cases, each program will, at some point, begin to reduce services to the client and stabilize or close the case. This part of the treatment process may be anxiety-producing for many clients. Clients must be prepared for termination or stabilization and programs must make sure that this occurs when the client is ready. A poorly handled termination can undo many of the good effects of a program. The essential questions of case management for termination/stabilization include:

(1) Does the program have criteria for determining the timing and procedures for termination or stabilizing cases?

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* Workers will find that many abusive or neglectful families are resistant to services. This is seen by many as a "cry for help." Attempts to make contact with resistant clients may be viewed as an important part of the treatment process.

(2) Are the program's termination/stabilization criteria met?

(3) Is the client prepared for termination/stabilization well in advance of its occurrence?

(4) Is the time between the maximum progress and termination/stabilization minimized?

Follow-Up: Although most programs have not undertaken systematic follow-up of terminated or stabilized cases, this step is regarded as an integral extension of the treatment process. During follow-up a program can help clients resume a stable life without services. Follow-up can be beneficial to the client while helping the program to better understand what impacts it has made. The essential questions of case management for follow-up include:

(1) Does the program have policies regarding follow-up of terminated/stabilized cases?

(2) Are the program's follow-up requirements met?

(3) Are follow-up contacts monitored?

(4) Is the client's progress monitored during follow-up?

Continuity and Coordination: Cases should be managed in a coordinated and continuous way. Programs should strive to reduce duplication of services provided to clients and turnover in staff handling for a given case. Essential questions of case management related to continuity and coordination include:

(1) Is the amount of turnover of the case manager for individual cases minimized?

(2) Is turnover in administrative, casework and other treatment staff minimized?

(3) Are methods for both formal and informal internal communication among staff on cases established?

(4) Are the links between the following made explicit: intake information and goals of treatment; goals of treatment and treatment plan; progress and changes in treatment plan; progress and termination?

(5) Are procedures established to ensure that clients do not unnecessarily receive duplicative services, particularly during intake?

Client Participation: The client should be encouraged to participate actively in his or her own treatment. Participation can take many forms: clients can be included in initial diagnosis and ongoing review sessions; clients may define their own goals of treatment; clients may keep their own records to complement those kept by the staff; clients might even be asked to form an evaluation board to provide feedback to the program on policies, staff hirings and changes in service procedures.

Regardless of the form, client participation should be seen as an adjunct to treatment, not separate from it. Client participation can reduce the resistance of clients toward treatment, reduce the client's own alienation, enable the program to be more responsive to the clients' needs, and divert some of the workers' confused feelings of being an advocate for both the parent and the child. However, depending on the form chosen, direct participation can also be a tremendous threat to workers. It can take a great deal of time and requires a great deal of sensitivity. In addition, the program will not always be able to act on client suggestions, and this can result in unresolved conflict. The essential questions of case management with regard to client participation include:

(1) Has the program specified procedures for client participation? Will clients be involved before, during, or after decision-making about their case? Are clients to be involved during initial diagnosis and ongoing reviews?

(2) Has the program specified which clients are to participate? Are members of the client's family to be included?

(3) Is the program's client participation policy carried out as specified?

Program Ethics: There are certain universal, abiding principles of service, ethics and professionalism which apply to work in child abuse and neglect. High standards of practice, which include honesty, confidentiality, informed consent, and respect for one's colleagues should be kept in mind when managing cases. The essential questions of case management with regard to program ethics include:

(1) Does the program have provisions for confidentiality of records?

(2) Is informed consent obtained from all clients for treatment of children, for disclosing information about the client, for obtaining information about the client from other agencies?

(3) Is careful consideration given to informing the client of decisions made about him or her?

Program Priorities: Sensitivity to how cases are being managed is important for effective delivery of services. Among the more important concerns for programs are the following:

(1) Does the program have an internal method for evaluating the quality of case management procedures? Are all workers included in carrying out this internal quality check?

(2) If certain case management criteria of the program are not being met, what is done about it?

(3) Is staff time monitored to determine whether or not a disproportionate amount of time is being spent on case management or general program management rather than on direct treatment?

Information to be Maintained on Clients

Some form of case record should be maintained on every client served.* Several programs in the child abuse and neglect field currently maintain records on families rather than individuals. There are advantages to this approach if the program is truly serving the family as a unit and looking for changes in the family instead of changes in the individual members of the family. However, family records do not allow for careful monitoring of individual progress.

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* In maintaining records on clients, programs must pay very careful attention to issues of privacy and confidentiality. While courts may have the right to subpoena client records, appropriate safeguards must be maintained to ensure that information about clients is only available to those authorized to have access to it.

We believe that it is best for most programs to maintain records on each member of the family who is directly being served by the program, even though some information may be duplicated from one record to another. These records should, of course, be organized in such a way that the total family picture is not lost.

The information maintained on clients will vary from one program to another, depending on a program's own objectives as well as its responsibilities to other agencies. Still, there are certain types of information, discussed later in this section, that are minimum essentials. Maintenance of this minimum information will assist the primary worker in understanding the client's needs and how those needs are being met. It is not sufficient for the worker to carry this information in his or her head. Written information will also ensure that (1) all other workers on a given case will know what is happening on that case; (2) if there is worker turnover, new workers will have access to critical information needed for continuity of services; and (3) the program has proper documentation for legal and other proceedings, and for evaluation of the effectiveness of its services.

Historically, at least in the social work field, information on clients has been maintained in the form of narratives, written dialogues of what occurs on every contact with a client. Narratives are very time consuming, and often difficult to use for reference, but not without value. When designing their case record formats, programs should attempt to incorporate some narrative reports to cover the minimum information requirements outlined below. At the same time, programs should be identifying ways of recording other information in summary formats or at least more graphically, to facilitate reference and review.

Minimum information to be maintained on adult clients: The case record should include certain background or demographic information on the case as well as a case history. This information will be useful in designing the initial service plan and for reference at later points in the treatment process, particularly if it clearly identifies the client's primary problems which should be the focus of service. Form VII-A is a sample of the type of intake form that might be used to record this information. This form should be tailored to suit a program's special needs, keeping in mind other forms a program may be required to complete.

The case record should also include a specification of the goals of treatment and the treatment plan developed in conjunction with these goals. Such goals and treatment plans should be reviewed periodically and changes in them or progress made toward them recorded. Form VII-B is a sample of the format in which goals and treatment plans could be recorded. This form could be completed at intake and at regular intervals thereafter. The specific categories used in a form such as this can vary, depending on the types of clients seen by the program and the range of problems they have. (This particular list reflects the

characteristics that, according to the child abuse and neglect literature, are thought to be related to the potential for abuse or neglect.) A section for recording information on recurrence of abuse or continuing neglectful behaviors could also be included in this form.

The case record should also include information on the services the client is receiving, both from the program and from other agencies in the community. Recording such information will force the treatment worker to be aware of what is happening to the client. Form VII-C is a sample service summary, both by type and by frequency. Programs may wish to use brief narratives to accompany this summary information.

Finally, information relating to termination and any follow-up contacts with the client after termination should be recorded in the case record. Included with this information should be a report on what was accomplished during treatment, the reasons for termination, and specific plans for either follow-up by the program or referral to other agencies. In addition, each follow-up contact with the client after termination should be noted in the record, with comments on the client's progress.

Minimum information to be maintained on children: Certain background and case history information should be included in the child's record. Form VII-D is an example of what might be included on an intake form. Depending on the focus of the program, the detail of the case history can be expanded or reduced.

The case record should also include information regarding the primary problems that are to be the focus of treatment, the goals of treatment, and the treatment plan. Problems can be recorded within general areas of child development such as physical characteristics and growth patterns, socialization skills and behavior, cognitive and language development, motor skill development, and interaction patterns. As tests are administered, results should be recorded. Form VII-E is an example of the format in which this information could be maintained. It may be desirable to add information on recurrence of abuse and neglect.

The case record should include information on the type and frequency of the services the child is receiving. A summary format, such as that depicted by form VII-F, is suggested, but narrative accompanying these data could be helpful.

Finally, the case record should include information relating to termination and any follow-up contacts with the child. The record should show what was accomplished during treatment, the reasons for termination, and specific plans for either follow-up by the program or referral to other agencies. Also, each follow-up contact with the child after termination should be noted in the record, with comments on the child's progress.

Some comments and cautions: Besides the information specified above, there are many events, observations and comments that programs will find essential for inclusion in a case record. We have attempted to specify the minimum needs, which would take a minimum of the workers' time to record, and which are easy for a program to analyze; beyond this minimum, program goals and requirements should dictate what is necessary and useful. The case record should be viewed primarily as a tool for workers to meet the clients' needs. Many programs will be completing forms on clients to meet local, state and federal requirements.

The information contained in the forms suggested in this booklet summarize the situation of the child and the parents, as well as the program's activities to help them. Such a summary can provide a quick overview of each case, without forcing someone to read through a bulky case history to find salient or important information every time it is needed. The information in these forms can also be used to evaluate the effectiveness of the program, the progress of a treatment plan, and the performance of individual workers. If these forms are used, an effort should be made to avoid duplicating other existing forms. If other forms must be filled out for reimbursement purposes, a central register, or various other social service information systems, an attempt should be made to devise one uniform form to comply with all these requirements; usually the information is similiar, if not identical, and only the format is different.

These suggested forms are detailed and extensive; they require time and thought to complete accurately. These forms were developed as part of a detailed evaluation of 11 HEW funded demonstration treatment centers. As such, they may provide more information than the average service program may be reasonably able to collect.

FORM VII-A: ADULT CLIENT INTAKE FORM

1. Client's Name: _____

   Address: _____

   Home phone: _____

   Office phone: _____

2. Mate's name: _____

3. Date Report Received: ___/___/___
   mo day yr

4. Source of Referral:

   Name: _____

   Agency: _____

   Phone number: _____

5. Reason(s) for Referral (brief description of incidents prompting the report):

6. Case Status:

___ Abuse established	___ Neglect established
___ Strong indication of abuse	___ Strong indication of neglect
___ Weak indication of abuse	___ Weak indication of neglect
___ Indication of potential abuse	___ Indication of potential neglect

7. Severity of Case:

For Abuse	For Neglect
___ Death due to abuse	___ Death due to neglect
___ Severely injured	___ Severely neglected
___ Moderately injured	___ Moderately neglected
___ Mildly injured	___ Mildly neglected
___ Emotional abuse	___ Emotional neglect
___ Sexual abuse	___ Failure to thrive
___ Potential abuse	___ Potential neglect

8. Person(s) identified as responsible for abuse/neglect (check all that apply)

   ___ Mother/mother substitute

   ___ Father/father substitute

   ___ Other (specify) _____

   ___ Unknown

9. Previous record/evidence of abuse/neglect by perpetrator(s) (check all that apply)

   ___ Record/evidence of abuse

   ___ Record/evidence of neglect

   ___ No record/evidence of abuse and neglect

   Briefly describe the previous incident(s):

10. Legal actions taken to date (check all that apply)

    ___ Case reported to legally mandated agency(s)

    ___ Court hearing held

    ___ Court supervision, child at home

    ___ Child removed from home temporarily (1 day to 2 weeks)

    ___ Child placed in foster or other longer term care

    ___ Child removed from home permanently

    ___ Criminal action against abuser/neglector

    ___ Other (specify) _____

11. Other agencies interested in case

    Name _____
    Agency _____
    Phone number _____
    Explain _____

    Name _____
    Agency _____
    Phone number _____
    Explain _____

    Name _____
    Agency _____
    Phone number _____
    Explain _____

HOUSEHOLD CHARACTERISTICS

12. Date of birth and sex of children in family

Child involved in abuse/neglect

Name	Date of Birth	Sex	Custody Status
	/ /		
	/ /		
	/ /		

Other children in family

	/ /		
	/ /		
	/ /		

13. Adult household member(s) (enter the number of individuals in each category in the appropriate space)

___ Natural mother
___ Mother substitute
___ Natural father
___ Father substitute
___ Grandparent
___ Other relative
___ Other(s)

14. Approximate ages of parent(s)/parent substitute(s)

___ Mother/mother substitute
___ Father/father substitute

15. Marital status of parent(s)/parent substitute(s)

___ Legal marriage
___ Consensual union
___ Never married
___ Divorced/separated
___ Widow/widower
___ Marriage partner temporarily absent
___ Marriage partner permanently absent
___ Unknown

16. Level of education completed

Mother/ substitute	Father/ substitute	
___	___	No high school degree
___	___	High school degree
___	___	Some college/vocational training
___	___	College graduate
___	___	Post graduate

17. Ethnicity/race of parent(s)/parent substitute(s)

Mother/ substitute	Father/ substitute	
___	___	Caucasian
___	___	Black
___	___	Spanish surname
___	___	American Indian
___	___	Other (specify) _____

18. Estimated yearly family gross income

From employment $_____
From public assistance _____
From other sources _____

19. Employment of adult household members

Name	Occupation	Employment Status

CLIENT'S NEEDS

20. Primary problems of client which help explain the actual or potential abuse/neglect situation (check all that apply)

___ Marital problems
___ Job related difficulties
___ Alcoholism
___ Drugs
___ Health problem (physical)
___ Mental health problem
___ New baby in home
___ Argument/physical fight
___ Financial difficulties
___ Mental retardation of parent
___ Pregnancy
___ Heavy continuous child care responsibility
___ Physical abuse of spouse
___ Recent relocation
___ Overcrowded housing
___ History of abuse as child
___ Normal method of discipline
___ Social isolation
___ Other (specify) _____

21. Elaborate on client's particular problems:

FORM VII-B: ADULT CLIENT'S GOALS OF TREATMENT AND TREATMENT PLAN

PROBLEM AREA	GOAL(S)	SERVICES PLANNED	SERVICE PROVIDER(S)
General Health:			
Personal Habits (drugs, alcoholism):			
Stress From Living Situation:			
Housekeeping:			
Child Care:			
Sense of Child as Person:			
Behavior Toward Child:			
Awareness of Child Development:			
Isolation:			
Ability to Talk Out Problems:			
Reactions to Crisis Situations:			
Way Anger is Expressed:			
Sense of Independence:			
Understanding of Self:			
Self Esteem:			
Other:			

FORM VII-C: SERVICES PROVIDED TO ADULT CLIENT

Client's Name _____

NOTE: Be sure to record amount of service provided, using units specified under specific service (e.g., no. hours, no. sessions, etc.). "Project" = services provided to client by the project and "Other" = services received by the client from another agency.

SERVICE CATEGORIES — Month →	Project	Other	Project	Other	Project	Other	Project	Other	Project	Other	Project	Other
Psychological or other testing (no. times)												
Case Review by Diagnostic Team (no. times)												
Social Work Counseling (no. contacts)												
Parent Aide/Lay Therapist Counseling (no. contacts)												
Individual Therapy (no. hours provided)												
Group Therapy (no. sessions attended)												
Parents Anonymous (no. sessions attended)												
Couples Counseling (no. hours provided)												
Family Counseling (no. hours provided)												
Alcohol Counseling (no. times)												
Drug Counseling (no. times)												
Weight Counseling (no. times)												
Family Planning Counseling (no. hours provided)												
24 Hour Hotline (no. of calls)												
Crisis Intervention (no. contacts)												
Child Management Classes (no. sessions attended)												
Job Training (no. sessions attended)												
Homemaking (no. times)												
Medical Care (no. visits)												
Residential Care for Child (no. nights)												
Day Care (no. visits)												
Crisis Nursery (no. visits)												
Welfare Assistance (Yes or No)												
Auxiliary Services: babysitting (no. times)												
Auxiliary Services: transportation (no. rides)												
Emergency Funds (no. dollars)												
Other (specify)												

FORM VII-D: CHILD INTAKE FORM

Name _____

Address _____

Phone _____

Parents _____
Mother

_____
Father

Date Report Received ___/___/___
mo day yr

Date of Birth ___/___/___
mo day yr

With whom is child living? _____

Who has legal custody of child? _____

_____

School & District _____

CASE HISTORY

Description of injury/neglect:

Explanation of how it occurred:

Legal actions taken to date: (check all that apply)

___ Case reported to legally mandated agency(s)
___ Court hearing held
___ Court supervision, child at home
___ Child removed from home temporarily (1 day to 2 weeks)
___ Child placed in foster or other longer term care
___ Child removed from home permanently
___ Criminal action against abuser/neglector
___ Other (specify) _____

Sex:

___ Male ___ Female

Ethnicity/Race:

___ White ___ Black ___ Spanish speaking
___ Other (specify) _____

Special Characteristics of Child:

___ Premature
___ Mentally retarded
___ Product of multiple birth
___ Emotionally disturbed
___ Adopted/foster child
___ Unwanted pregnancy
___ Unliked child

Previous record/evidence of abuse/neglect (check all that apply)

___ Record/evidence of abuse
___ Record/evidence of neglect
___ No record/evidence of abuse and neglect

Explain:

Severity of Case:

For Abuse	For Neglect
___ Death due to abuse	___ Death due to neglect
___ Severely injured	___ Severely neglected
___ Moderately injured	___ Moderately neglected
___ Mildly injured	___ Mildly neglected
___ Emotional abuse	___ Emotional neglect
___ Sexual abuse	___ Failure to thrive
___ Potential abuse	___ Potential neglect

FORM VII-E: CHILD'S GOALS OF TREATMENT AND TREATMENT PLAN

AREA	PROBLEMS NOTED	GOALS	SERVICES PLANNED	SERVICE PROVIDER(S)
Physical Characteristics and Growth Patterns	Exam results:			
Socialization Skills and Behavior	Test results:			
Cognitive/ Language Development	Test results:			
Motor Skill Development	Test results:			
Interaction Patterns with Parents/Other Family Members				

FORM VII-F: SERVICES PROVIDED TO CHILD BY PROGRAM OR OTHER AGENCY

Child's Name _____

NOTE: Be sure to record amount of service provided using units specified under specific service (e.g., no. hours, no. sessions, etc.)

SERVICE CATEGORIES Month →						
Day Care (no. hours						
Therapeutic Day Care (no. hours)						
Play Therapy (no. sessions)						
Individual Therapy (no. sessions)						
Medical Care (no. times)						
Psychological Testing (no. tests)						
Speech or other Specialized Therapy (no. sessions) SPECIFY TYPE _____						
Foster Care (no. days)						
Residential Care (no. days)						
Crisis Nursery (no. days)						
Other (specify) _____						
Other (specify) _____						
Other (specify) _____						

CHAPTER VIII: MONITORING PROGRAM RESOURCES

Program managers should know how the program's funds are being spent, how staff members are spending their time, the cost of different program activities, and the unit costs of different activities. In addition, the program manager should be aware of how the allocation of resources changes over time and whether or not there are less expensive ways of carrying out the program's activities. With this information, program managers can increase the efficiency of the program, improve use of staff, ensure that program resources are used in priority areas, and plan more effectively and efficiently for future activities and funding needs. The purpose of this chapter is to explain an accounting method that will help program managers obtain this information on resource expenditures.

In traditional cost accounting, program dollars are accounted for by line items such as rent, telephone and salaries. Although this method of cost accounting provides information on how money is spent in terms of the overall program, and is often necessary for administrative purposes such as accountability to funding agencies, it does not provide information on discrete program activities. It also does not tell a manager how staff members are spending their time nor does it take account of the program's donated resources. In resource accounting by program activity, all of a program's resources, whether paid for or donated, are accounted for in terms of allocations to specific, discrete program activities. This approach forces a program to account for all of its resources in a functional way.

Very simply, resource accounting by program activities consists of the following steps: (1) identifying all of the discrete activities of the program; (2) identifying all of the program's resources; (3) determining the time period to be covered; (4) determining how, within the given time period, all non-personnel resources are allocated to program activities; (5) determining how all personnel time and, thereby, personnel costs, for the same time period, are allocated to program activities; (5) calculating expenditures for the given time period by program activities; (7) determining how many units of different services were provided and, thereby, the unit costs of different services. The steps are elaborated below. They do not require much time, nor any special set of skills.

Step 1: Identifying Discrete Activities of the Program

The first step is to identify all of the discrete activities of the program. These activities should reflect specific services of the program (such as group therapy or community education) or activities that are necessary supports for the services (such as general management or staff development and training) rather than the tasks that are necessary to produce these services (such as writing or talking on the telephone). The activities should be discrete; that is, they do not overlap and are clearly distinguishable from each other. The listing should include every activity that the program undertakes.

Every program has a slightly different set of activities. Table VIII-A suggests a range of activities found in child abuse and neglect service programs.

Step 2: Identifying Program Resources

The second step is to identify all of the program's resources, whether paid for or donated. Some of these resources may be dollars from federal, state or local sources; other resources are personnel, paid or volunteer, regular or part-time, consultant or advisory. Finally, in addition to volunteered time, program resources may include donated items such as reduced rent or office equipment. It is important to distinguish donated from paid-for resources, and where possible, to estimate the value of donated resources.

Step 3: Determining the Time Period to be Covered

The third step is to determine what time period the resource accounting is to cover. Although any time period can be chosen for resource accounting, it is generally best to use one-month periods, since this will probably correspond to the program's current accounting procedures. In addition, one-month periods are long enough to allow for monitoring of the full array of program activities. Ideally, one would undertake the resource accounting every month as a routine part of program management; however, it is generally sufficient to conduct the resource accounting once per quarter.

Step 4: Determining Allocations of Personnel Resources

The fourth step is to find out how personnel resources are allocated to the various program activities during the time period. This is done by determining how each staff member spent his or her time during the time period, in relation to program activities. Thus, the salary or imputed salary can be distributed accordingly. It is important to do this for every person who regularly contributes to the program, whether paid or not. For those not paid by the program, estimates of what they would have been paid (what their time was worth) should be made.

TABLE VIII-A: CHILD ABUSE AND NEGLECT SERVICE PROGRAM ACTIVITIES

Project Operations:	General management Staff development and training Program planning
General Case Activities:	Case management and ongoing case review Intake and initial diagnosis Outreach Court case activities Multidisciplinary team
Treatment Services to Parents:	Psychological and other testing Individual counseling Parent aide/lay therapist counseling Individual therapy Group therapy Parents Anonymous Couples counseling Child management classes 24-hour hotline counseling Crisis intervention Alcohol counseling Drug counseling
Treatment Services to Children:	Therapeutic day care Day care Residential care Crisis nursery Play therapy Specialized therapy Psychological and other testing
Treatment Services to Families:	Residential care Family therapy
Supportive Services to Families:	Advocacy with legal problems Advocacy with income/employment problems Advocacy with housing problems Medical care Homemaking Family planning counseling Babysitting Transportation Emergency funds
Community Activities:	Prevention Community education Professional education Technical assistance and consultation Legislation and policy Coordination

The easiest way to determine personnel resource allocations is to have each person working on the program keep track of his or her time on a daily basis. Form VIII-B is an example of how time can be recorded. At the end of the given time period, tally how many hours a given individual worked on the different program activities. Then allocate the person's hourly salary and fringe benefits or imputed salary among the program activities, as indicated by the proportions of time. If overtime is paid, the extra payments should be allocated to the proper activity. Tally the allocations for all personnel for each activity to establish the total personnel expenditures by activity.

The information collected on how staff members spend their time is beneficial to program managers and staff members, even if dollar values are not ascribed to it. One can sum the number of hours all staff members spent on each of the different program activities to determine how the staff as a group allocate their time. Or, one can group staff members according to their different roles (for example, regular staff, volunteer, consultants) and determine how these different groups contribute to the program.

Step 5: Determining Allocations of Non-Personnel Resources

The fifth step is to determine how all non-personnel resources should be allocated to program activities for the time period selected. Identify all non-personnel expenditures for the time period (such as rent, telephone, printing) and record how much was spent on each (or if the item was donated, how much it was worth) on a form such as VIII-C. Estimate how each expenditure should be allocated across program activities.

> Examples: If $200 was spent during the month on printing and 50% of the printing was for community education activities, 30% was for research instruments and the remainder was for client forms, allocate $100 to Community Education, $60 to Research and $40 to Case Management.
>
> If $800 was spent on rent during the month and the office space is equally occupied by the day care program, the case workers, and administrative staff and the research staff, allocate $200 to day care, $200 to Case Management, $200 to General Administration, and $200 to Research.

These non-personnel expenditures will probably account for a small portion of the total budget. Therefore, while accuracy is important, precision in allocating these costs among program activities is not essential. Instead, allocations should be made to the nearest 5-10%. Once all of these non-personnel expenditures have been allocated to

various program activities, expenditures by activity can be summed to determine the total non-personnel expenditure for the given activity.

Step 6: Calculating Expenditures by Activities

The sixth step is to combine all non-personnel and personnel resource allocations in order to determine what the total expenditures for different program activities were during the time period. This is done simply by summing the calculated expenditures from the two categories for each activity. This will result in important management information on how all program resources were utilized during the time period and what the costs of the different program activities are. A program manager may wish to convert these data into percents rather than raw dollar figures; then, as data are collected over several months, comparisons will be easier.

Step 7: Determining Unit Costs of Services

In addition to understanding what it is costing a program to offer various services, a program manager will want to know what the unit costs of different services are. For example, how much does it cost to provide one day of day care to one child? Or, what does one case review by the multidisciplinary team cost?

There are several program activities for which it will be inappropriate to determine unit cost. General management and research are two obvious examples. However, it is possible and desirable to determine unit costs for all direct services to clients. By studying changes in unit costs over time, the program manager can determine the efficiencies within the program. For example, assuming that the quality of the service remains unchanged, if the unit cost of a service declines over time as the number of clients using the service increases, a program is said to have "economies of scale." In other words, the program can increase its service provision to clients without significantly increasing its costs or reducing the quality of the services.

In order to calculate the unit costs of services, the final step in the resource allocation, it is necessary to determine how many units of a given service were offered during the time period and divide that number into the total costs for that service during the month. Form VIII-D suggests a format for doing this and possible unit measures. Information on units of service provided may be maintained on individual cases using a form such as Form VII-C presented in Chapter VII.

By completing the resource accounting procedure described above on a regular basis, the program manager can learn a great deal about the program. The time allocation of staff members provides clues about where they feel program priorities lie and may suggest ways in which staff time should be changed. The overall cost allocations will alert program managers to the true costs of pursuing different activities, information

useful in future planning and budgeting, and in making short-term refinements in program operations. The unit costs will also help the program manager to better understand the service capacity of the program.

Some Comments and Cautions

Accounting for program resource expenditures is a relatively simple process that can have invaluable benefits for the program manager if done well. The cost data can tell the manager how staff members are spending their time, where project resources are going and most importantly, how project expenditures change over time. The manager need not be worried about precision in carrying out the analysis, but should strive for accuracy. The accounting will be most effective if done for one-month periods, and if done periodically during the course of the year.

FORM VIII-A: TIME ALLOCATION

Instructions

1. For the selected components on which you spend time, please enter the number of hours spent each day.
2. The hours need not sum to any particular total and should not include any part of lunch, time off, etc.
3. This form should be filled by or for all persons who work in any regular capacity directly for the program.

Day of Month →		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Community and Professional Education																	
Coordination																	
Technical Assistance and Consultation																	
Program Planning and Development																	
General Management																	
Project Research																	
Staff Development and Training																	
Direct Services to Clients	Intake and Initial Diagnosis																
	Case Management and Regular Review																
	Court Case Activities																
	Psychological and Other Testing																
	Multidisciplinary Team Case Review																
	Individual Counseling																
	Couples Counseling																
	24 Hour Hotline Counseling																
	Group Therapy																
	Parent Education Classes																
	Crisis Intervention																
	Day Care																
	Crisis Nursery																
	Homemaking																
	Medical Care																
	Babysitting/ Child Care																
	Transportation/ Waiting																

FORM VIII-B: NON-PERSONNEL EXPENDITURES

Instructions

1. Enter all non-personnel expenditures for the month.
2. Determine how each was utilized in relation to program activities.

Item →											
Payment This Month →											
	%	$	%	$	%	$	%	$	%	$
Community & Professional Education											
Coordination											
Technical Assistance & Consultation											
Program Planning & Development											
General Management											
Project Research											
Staff Development & Training											
Direct Services to Clients: Intake & Initial Diagnosis											
Case Management & Regular Review											
Multidisciplinary Team Case Review											
Individual Counseling											
24 Hour Hotline Counseling											
Group Therapy											
Parent Education Classes											
Crisis Intervention											
Day Care											
Crisis Nursery											
Homemaking											
Medical Care											
Babysitting/Child Care											
Transportation/Waiting											

FORM VIII-C: COSTS OF UNITS OF PROJECT SERVICES

Instructions

1. For each selected service provided by the project, indicate total quantity provided this month.
2. Divide number of units into total cost of service to determine unit cost.

SERVICE	UNITS	QUANTITY	COST PER UNIT
Intake & Initial Diagnosis	Intakes		
Case Management & Regular Review	Av. Caseload This Mo.		
Court-Case Activities	Cases		
Psychological & Other Testing	Person Tests		
Multidisciplinary Team Case Review	Reviews		
Individual Counseling	Contacts		
Couples Counseling	Contacts		
Family Counseling	Contacts		
24 Hour Hotline Counseling	Calls		
Group Therapy	Person Sessions		
Parent Education Classes	Person Sessions		
Crisis Intervention	Personal Contacts		
Day Care	Child Hours		
Crisis Nursery	Child Hours		
Homemaking	Contacts		
Medical Care	Visits		
Babysitting/Child Care	Hours		
Transportation/Waiting	Rides		

CHAPTER IX: ACTIVITIES IN THE COMMUNITY

An effective service program should be continually active in the community. Reaching those people who can benefit from the program's services requires community education to promote awareness of the problems of abuse and neglect and the services available to deal with the problem. To establish good relationships with other agencies dealing with abuse and neglect, coordination is imperative, for no agency serves its clients in isolation. Developing an effective community education and coordination program can be a difficult task. Priorities must be set, since no program, by itself, can expect to fill an entire community's educational needs in the area of abuse and neglect. Coordination with existing agencies must be done in the context of these agencies' already established roles and perspectives.

The purpose of this chapter is to clarify the need for relationships with other community agencies and the community at large, and to identify appropriate coordination and educational activities in the community. There are no established guidelines for delineating the "one right way" to carry out community education or coordination. Each program's staff will develop its own priorities and approach, based on the program's goals and the community in which it operates.

Community and Professional Education

There are several reasons for devoting some program resources to community and professional education. Presentations on the dynamics of abuse and neglect and its treatment can change community attitudes toward these problems and encourage those who recognize an abuse or neglect situation, in themselves or others, to seek assistance where it is available. Where needed services are not available in the community, educational efforts can create awareness of such gaps. Presentations for professional groups, including physicians, nurses, teachers, police, court personnel, social workers and others likely to deal with abuse and neglect situations, will increase the knowledge and skills of those currently working with abusive and neglectful families. They will also be instrumental in reaching those professionals who have little knowledge of abuse and neglect, who may have been reluctant to get involved, or who have been working in isolation from the mainstream of service provision.

Because one program cannot meet every community education need, it is important to identify the purpose of these educational activities and the groups in the community who are to be reached. In some community education endeavors, the emphasis will be specifically on an explanation of the program, perhaps even on recruiting volunteers for it. Others will have as their purpose a broader discussion of abuse and neglect, its causes, approaches to treatment, and legal responsibilities for people identifying suspected cases. A community education program for which the purposes and target groups have been planned in advance is far more likely to serve the program's and community's needs than an unsystematic program based on simply responding to requests as they are received. This is especially true in designing an effective professional education program, since the most important groups to reach may be those who have not yet had any exposure to identification and treatment of abuse and neglect, or groups that are not aware of the range of agencies and services available to address the problem. Most important, careful planning for the educational component of a program will reduce susceptibility to the common problem of expending great effort on public relations and education activities before developing the program's readiness for the subsequent increase in client referrals.

In staffing educational presentations, many programs have found it valuable to give all staff members some responsibility, since the range of staff perspective and expertise (social workers, physicians, psychologists, nurses, homemakers, lay therapists) can be used. In addition, participation by all staff members in community and professional education enhances their sense of responsibility and commitment, and helps them to develop professionally. It also helps reduce "burnout" by diversifying activities for staff.

A valuable adjunct to educational presentations is a method for evaluating the presentations. The purpose of such an evaluation is to determine whether the goals of the presentation have been achieved and if the audience found the subject matter useful -- for example, whether the audience's knowledge about child abuse and neglect has increased, or more positive attitudes had been promoted. A simple questionnaire can be tailored to the audience and material presented to provide this evaluative feedback at the end of the presentation.

Coordination

Coordination with key agencies, including protective services, courts, schools, hospitals, and law enforcement, is essential in an effort to develop a more effective network for identifying and serving families where abuse and neglect occur. In a given community, other agencies involved in identifying and treating these cases may also be important, such as mental health centers, visiting nurses and public health agencies, and private family service agencies.

The purpose of coordination is to develop a service network in which the various agencies' roles and relationships are clear, and to provide the best system for helping families by avoiding overlapping functions and ensuring that all important services are available in the community. Coordination at the agency level is necessary to establish each agency's responsibility for the different functions in service delivery -- identification, investigation, treatment planning, treatment, and follow-up. In addition, coordination at the individual case level is important when more than one agency is working with a client. It is essential in this situation to coordinate information on the client's needs, progress, and the services being provided to avoid duplication and provide the best service for the client.

A well coordinated system in a community can be difficult to achieve, since agencies usually have established procedures and may have differing perspectives or approaches to handling abuse and neglect. Another agency, particularly a new program, can be viewed by existing agencies either as a needed complement to services they provide or as an "interloper," duplicating or threatening the role of existing agencies.

Therefore, in developing any new program it is important to begin coordination efforts from the outset. This is one of the primary purposes of the needs assessment, discussed earlier in Chapter III. When the needs assessment is undertaken, the input of existing agencies can concurrently be incorporated into the development of the planned program and working relationships, which are mutually beneficial and based on the perspectives of both agencies, can be initiated.

Once such communication channels have been established, agencies can jointly determine what coordination procedures are most needed and would be beneficial. Areas for consideration include referral procedures among agencies; the types of cases to be accepted by each; the roles the agencies will play in investigating cases, providing various types of treatment, and in day-to-day management of the case; and procedures for sharing information on the diagnosis and progress of cases with which more than one agency is working. A written agreement may have value in establishing interagency procedures. A sample of such an agreement is provided here in Table IX-A. Actual agreements between agencies will vary depending on the kind and extent of responsibility to which all parties agree.

TABLE IX-A:

SAMPLE COOPERATIVE WORKING AGREEMENT -- DIVISION OF SOCIAL SERVICES (a state agency) AND THE CHILD CENTER (a voluntary agency)

The Division of Social Services (DSS) is mandated by law to investigate reported cases of child abuse and neglect; to report such cases to the Central Registry; and to offer protective social services to families referred for possible or actual child abuse.

The Child Center provides specialized treatment services to abused or potentially abused children and their families.

1. Suspected or possible abuse cases referred to the Child Center will in turn be referred to DSS.

2. The DSS worker will handle referral as any other abuse referral, i.e., making a home visit, providing a written report to the court and Central Registry within 90 days.

3. Following the home visit by the DSS worker, a meeting will be set up between DSS and the Child Center on those cases that the Child Center is considering for intake.

4. The Child Center worker and the DSS worker will work together in formulating an effective treatment plan.

5. The DSS worker will continue the investigation and attempt to motivate the client to seek services offered by the Child Center.

6. The DSS worker will provide the Child Center with any pertinent information.

7. The Child Center will provide the DSS with a copy of the treatment plan and regular feedback on progress, including a written summary at least every other month.

8. The DSS worker will monitor the family progress through information received from the Child Center while the family is in treatment.

Effective interagency coordination is often enhanced by agencies' participation on each other's Advisory Boards, by staff sharing agreements, or by interagency contracts or purchase-of-service agreements. All of these increase the agencies' knowledge of each other's activities and provide mutual support to fulfill agency and client needs.

Coordination on individual cases with which two or more agencies are involved may be less formal, but is integral to effective case management. Often, coordination on cases is established through the informal contacts that workers in agencies establish with each other. Consequently, formal procedures are not always needed, but a realistic appraisal should be made, and informal contact should not be relied on as a method for sharing information on joint clients if it is not likely to occur spontaneously. In such cases, developing prepared forms for interagency progress reports and information sharing on cases can be valuable. Establishing a routine for inviting the primary worker on a case from other agencies to attend all case conferences is another way of ensuring adequate coordination on joint cases. While these types of procedures are fundamental to an individual workers' effective case management, they can be facilitated by good working relationships at the agency level. Conversely, poor working relationships can hamper even the best worker's achievement of needed coordination on cases that involve other agencies.

Continuing Needs Assessment

Just as coordination should begin at the time of an initial needs assessment, continuing needs assessment is a vital part of effective coordination, in order to keep abreast of problems in the community service delivery system and to work effectively with other agencies to alleviate these problems.

The difficulties encountered in obtaining needed information for an initial needs assessment will still be problems, and part of an effective coordination and community education effort should be encouraging agencies in the community to maintain the kinds of data needed to continually evaluate the community's ability to serve cases of abuse and neglect. Of particular importance is regular feedback on the number of cases being identified each year by each principal agency, the sources of cases identified, the proportion of cases that are investigated and substantiated, and the proportion of cases actually receiving services. The Central Registry may be the best unit for maintaining this information, and coordination and education efforts can be aimed at ensuring (1) that all pertinent agencies and professionals use the Registry, (2) that the reporting form contains all the important items of information and (3) that the results are reported back to user agencies. Where there is no Central Registry, or it is not the best center for handling this information, some other approach should be developed. Perhaps a Child Coordinating Committee, with representatives from all agencies and a small staff to collect and organize the necessary data, could be

established. Alternatively, the health and welfare planning agency in the community may be suited to this task. Whatever the form, adequate data for continuing needs assessment depends on commitment from all agencies to tabulate the essential items in a uniform manner.

Some Comments

When a new program is being established, many problems can occur, many mistakes are made. One is the tendency to concentrate totally on internal program development, remaining rather isolated from what other agencies in the community are doing. A second is the tendency to undertake extensive community education and public relations activities before fully developing a working treatment program that can provide services when required. In considering community education and coordination components for a new program, both of these extremes must obviously be avoided. A program developed in isolation from the existing community service system runs the risks of ignoring the most important service needs and of alienating agencies essential to the service delivery process. A program heavily emphasizing public relations and education to the exclusion of developing promised services may find itself unable to meet the expectations that the community will have for it.

A FINAL WORD

The potential of death or severe impairment to a child in many abusive or neglectful situations presents a unique set of problems for people working in the field.

New child abuse and neglect programs must maintain a sensitivity and commitment to the people being served. Abusive and neglectful families lack the internal and external support systems normally available to other people. Their low self-esteem often mitigates against efforts to help them change their behavior and situations. Because of their previous failures, these families are often stigmatized by society, thus eliminating external supports and further reinforcing their poor sense of worth. Help in providing these missing support mechanisms is essential.

One very important service that new programs can offer is the development of a personal relationship with these families, to increase their self-esteem and help provide the motivation necessary to change behavior. Although a variety of treatment modalities can be used effectively, all should be based on respect and understanding of the individual receiving services and his or her unique problem. These people may require 24-hour support, large measures of love and concern, and continual human contact in order to break the cycle of rejection, brutality and failure which has been their history. Services which develop the strengths of these families, rather than magnifying their weaknesses, are often the most effective.

Choosing staff to work with abusive and neglectful families is a critical part of any program. There is an obvious need for professional skills and training, particularly diagnostic skills. There is, however, an equal if not greater need to select people who can love, support, parent, and empathize with abusive and neglectful families. A worker in this field must be able to accept limited success, at least in the initial stages of treatment. He or she needs to be able to deal with anger, hostility, rejection and overcompliance. Workers also need continual emotional support from their supervisors and the right to be flexible and creative in their work. Finally, workers need to be reassured that although the rewards may seem very limited, they can provide desperately needed services -- services that can be effectively provided by very few people.

APPENDICES

Case studies of four child abuse and neglect service programs follow. These cases, selected from a set of federal demonstration programs because they represent a range of possible program models, are included to provide the reader with real world examples of many of the issues discussed in the preceding document. These program descriptions are, therefore, examples of what might be, and not necessarily models of what should be.

APPENDIX A

THE FAMILY CENTER: ADAMS COUNTY, COLORADO

PROLOGUE

On a typical Thursday morning at the Family Center the social workers busily review the week's intake cases in preparation for the weekly Multidisciplinary Review Team Meeting. Immediately after lunch all staff members leave whatever they are doing and hurry to the Conference Room at the Department of Social Services offices. Several members of the team have already assembled. The Probation Officer, representing the Juvenile Court, is engrossed in conversation with the Assistant District Attorney; the psychologist from the Mental Health Center, seated at the table, is buried in some apparently important reading, and the project's consulting physician seems absorbed, perhaps thinking about a case seen earlier in the day. Just before the Center's Director calls the meeting together, the last three standing members of the Team arrive; the Protective Services Supervisor, the Health Department's representative, and the Team's only nonprofessional, a housewife from a nearby town.

Copies of the summaries of cases to be presented at the meeting are distributed. The participants are asked to read through the first case summary, which concisely presents identifying information about the parents and children, data on the cause of the referral, medical information and the social worker's evaluation and recommendations. Mrs. Kelly, recently divorced, had been given legal custody of her two children. The referral had come to the Center from a friend of the mother, who explained that Mrs. Kelly had been distraught and had threatened to kill herself and her children. The social worker "on call" that day learned that Mrs. Kelly was suffering from severe emotional problems resulting from her recent divorce and that she had, on several occasions, threatened to harm her children. After securing permission from the mother, the social worker brought the children to a physician for a medical examination and then placed them in the Center's crisis nursery. The father was located and agreed to take temporary custody of the children until Mrs. Kelly's condition stabilized. Because this was a clear-cut case of potential abuse, the recommendation was to assign the case to a Protective Services worker who would handle the necessary court work for transfer of custody and who would work with the mother, in conjunction with her primary therapist, a local psychiatrist.

The Multidisciplinary Team members ask questions concerning the mother's relationship with her psychiatrist, her response to giving up her children for a while, and the father's capability of caring for the

children. In this particular case, they concur with the recommendations of the Center staff member.

During the course of the afternoon, four more Center cases and three Protective Services cases are reviewed in the same way. The meeting finally adjourns at 5:00 P.M., and the Team members leave, exhausted but satisfied that they helped prepare the most accurate diagnosis and the best possible treatment plan for each case.

I. HISTORY

The Juvenile Court was the first agency in Adams County to call attention to the need for constructive intervention in abuse cases. A local judge had gained national recognition for his sympathetic approach in dealing with families who came before his bench, and the Probation Department supported the judge's philosophy of counseling, rather than incarcerating, parents who were charged with abuse.

The Adams County Department of Social Services (ACDSS), concerned about the rising incidence of child abuse, which was reported to have doubled each year since 1965, called attention to the need for improved methods for handling these cases. However, the Department's plan for adding staff to more adequately cover abuse cases was dashed when a state-directed budget freeze precluded new hiring.

In the meantime, other professionals in the community also recognized the importance of developing a more coordinated, comprehensive approach for dealing with the special problem of abuse. When news came of possible federal demonstration money, some social workers from ACDSS as well as representatives from other agencies, including Adams County Mental Health Center, the Child Advocacy Team, Adams County Juvenile Court and the Tri-County Health Department, convened in response to the "Request for Proposal" from the Office of Child Development. The pertinent community agencies banded together to suggest a multi-agency approach to child abuse, and developed the model for a program separately housed from, but administered by, ACDSS.

II. COMMUNITY CONTEXT

Adams County lies north of and adjacent to Denver. The county, with a population of 206,000, has seven incorporated small towns, but also has a large rural area. The county has several distinct socio-economic communities, from migrant farm laborers and farmers, to blue collar workers and middle income commuters. The most statistically significant minority group in the county is Chicano, which accounts for 16 percent of the county's population.

Although Colorado law required until 1975 that all reports of abuse or potential abuse be made to a law enforcement agency, in Adams County the Department of Social Services has traditionally received more initial reports than all police and sheriff's departments combined. Law enforcement agencies still receive a significant number of reports from the community at large; they do an initial home investigation of these reports, and if warranted, carry out a criminal investigation. ACDSS has separated the handling of abuse cases from those of the other Protective Services cases. Incoming neglect cases are evaluated by a separate intake unit, whereas abuse cases coming directly to the department are assigned immediately to a Protective Services worker, who provides both intake and ongoing treatment as needed. Treatment has traditionally involved either individual or family counseling and/or referral to other community agencies such as the Mental Health Center or the health department, Tri-County Health.

Until a few years ago the Probation Department of the District Court was the principal agency receiving community-wide child abuse referrals; however, the Court no longer investigates abuse referrals but sends all new reports directly to ACDSS or the Family Center for follow-up. The Court becomes involved only when either the Center or ACDSS files a petition to remove a child from the home.

The County's primary public hospital resource is Colorado General Hospital, a state-supported hospital located in Denver. The hospital, which houses the National Center for the Prevention and Treatment of Child Abuse and Neglect, has one of the most sophisticated child abuse identification and treatment programs in the country.

The various school districts in the county used to have a self-contained way of dealing with suspected abuse and neglect. Reluctant to report suspected cases because they were afraid to anger parents and because past experience proved that sometimes little intervention was provided, the teachers and other school personnel were made the prime target of the Family Center's community education effort. At present, the project has made agreements with each of the districts whereby suspected cases are referred to a Family Center liaison for that district.

III. PROJECT GOALS

The project staff has identified the following as the goals for the remaining months of the demonstration funding:

1. To foster a multidisciplinary approach in Adams County for the prevention, detection and treatment of child abuse;

2. To improve client functioning by providing responsive intake and treatment;

3. To demonstrate the role of a nurse as an important part of a child abuse team;

4. To determine the most effective treatment, within the context of a Department of Social Services, for abused children and their families;

5. To heighten community awareness about the dynamics and treatment of child abuse and about the need to report;

6. To increase the knowledge and involvement of school personnel in the child abuse services system;

7. To provide continuing child abuse coordination, referral and treatment services in Adams County after the federal funds have ended;

8. To develop a child abuse program model that will be applicable to other departments of Social Services in the state and around the country.

IV. ORGANIZATIONAL STRUCTURE

Although the project is distinct and separately housed from ACDSS, it is responsible to the department for administration and financial management. The project's fiscal matters are handled by ACDSS accountants, and the Department contributes financially to the Center by directly allocating some operating funds and by making child welfare payments for children eligible for placement in the Center's crisis nursery. ACDSS administration encourages the project to take the initiative for planning and program implementation, and the Center also has its own personnel policies and procedures because of its special funding status. Regular meetings are held between the Center director and the Department staff liaison person, the Supervisor of Social Services. Because of the model established under the grant, most abuse referrals coming to the Center are transferred after intake evaluation to the Protective Services Unit of ACDSS for ongoing treatment. This arrangement necessitates routine communication between the two agencies.

V. STAFFING PATTERNS

FIGURE 1: Organizational Chart

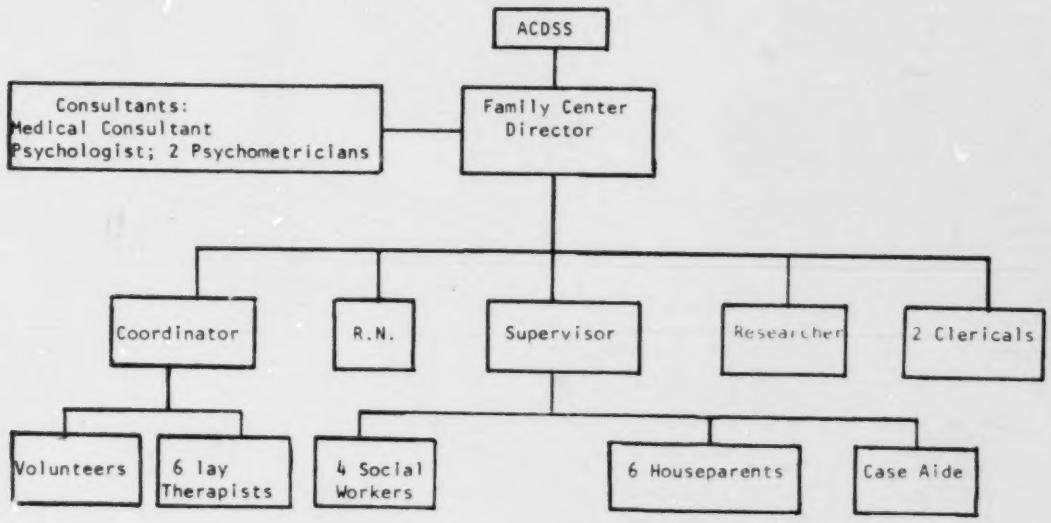


Figure 1 illustrates the project's organizational structure. The Center gradually expanded its staff during the course of the first year. The director, coordinator, four social workers, researcher and nurse were hired during the early implementation period between mid-August and early October 1974. The first clerical position was filled in November. The researcher, whose position was originally part-time, was made a full-time staff member in January 1975, and houseparents were also hired at that time. The lay therapy program component was put into operation with the hiring of six lay therapists in March. Relief houseparents were also hired in March. A case aide began in May and the second clerk-typist started in June. The supervisor, who began working with the project on August 1, 1975, completes the staff to date. The only two staff members whose titles do not describe their roles are the coordinator and nurse. The coordinator's responsibility is to supervise the lay therapy program, to organize the Community Relations Board, and to carry out some administrative tasks. The nurse spends about one-half of her time accompanying social workers on intakes involving physical abuse so that she can provide medical assistance; the remainder of her time goes into therapeutic treatment, professional education and medical care for the crisis nursery.

VI. PROJECT COMPONENTS

Community Education: The main conduit for community education is the Speakers Bureau, which was set up as a multi-agency effort to conduct programs on child abuse throughout the community. It consists of project staff and representatives from ACDSS, the Protective Services Division, Tri-County Health and the Multidisciplinary Review Team. All presentations of the Bureau are supplemented by evaluation forms that relate to how many people attended, their perspectives and their response to the information provided about the dynamics and treatment of abuse. The Bureau's first year has been very active in terms of the numbers of people provided with information, and there is evidence of an increase in public awareness of the Center, the reporting law and community services for abuse.

Professional Education: The first year of the project's School Referral Program was a success. Primarily concentrating on the public school districts, the Center assigned staff members as liaisons to each of the districts. Each staff member provided training programs for personnel in his/her district and also arranged referral procedures between the district and the project. Since the program began, in September 1974, the number of referrals from public schools has increased significantly over those of the previous year.

Training in child abuse has also been provided for other county Departments of Social Services, Denver Public Schools, the local community colleges, Head Start staffs, day care and foster parent organizations, Adams County Mental Health Center, and a variety of other professional groups, including physicians' office staffs, hospital staffs and ministers.

Coordination: In addition to the project's ongoing informal meetings with various agencies in the community, aimed at streamlining the local referral process, some of the Center staff are active in the Metropolitan Council on Child Abuse which seeks to effect a functional services system in the greater Denver area and even statewide. Several agreements have been made pertaining to coordination between the Center and other institutions or agencies. ACDSS and the Center have a written agreement on procedures for transfer of cases. All of the school districts in the area now have written procedures for working with the Center on abuse cases identified by school personnel. A verbal agreement has been made with the Mental Health Center concerning referral for treatment of project clients, and a written agreement has been signed with the Tri-County Health Department regarding mutual responsibilities for abuse cases that involve the Health Department staff and facilities.

The Center was also helpful in organizing a local chapter of Parents Anonymous, getting the P.A. leadership together with formerly abusive parents in the community. This effort resulted in the first Adams County P.A. chapter, started in May 1975.

Legislative Activity: The project director provided information and suggestions to legislators during their debate on the revision of the Colorado Child Abuse Reporting Act. A new statute, without appropriations, was passed in the spring of 1975, expanding the list of reportable offenses to include neglect, and basing the method of required response to cases on the Family Center approach, i.e., having a community-wide Multidisciplinary Review Team participating in treatment planning for all cases. The project director has also presented testimony at a legislative hearing on the need for giving children's services in general and child abuse programs in particular a higher funding priority.

Project Research: Project research has included extensive monthly tabulation and analysis of data on Center cases, monitoring of the Speakers Bureau and School Referral Program, and expansion of the project's internal evaluation to include assessment of abused children's functioning during and after treatment. This evaluation is being developed in conjunction with three consultants (two doctoral candidates and a university faculty member). The first step has been to review both the literature and others' experiences concerning a variety of developmental tests. This has led to choosing several tests that are appropriate as diagnostic tools for children's treatment planning and for assessing the effectiveness of various treatments. The general format will be, based on parental agreement, testing of all children in the project's caseload and in the crisis nursery, followed by testing during their subsequent months in treatment.

Intake and Initial Diagnosis: During the project's first year, non-management staff members have spent most of their time on intake and, therefore, have developed a process for efficiently handling this work. An "on call" system has been set up, an approach to be used for meeting the reported families and gaining their trust has been agreed upon, procedures for substantiating cases have been established, and formal, written follow-up reports to the sources that reported the cases have been initiated. When reports involve child battering, a social worker and the staff nurse make the initial home visit together. The nurse gives the child a preliminary physical examination and is responsible for any necessary medical follow-up. Transfer of cases to the ACDSS Protective Services Unit occurs after the Center social worker has completed the case evaluation and after the Multidisciplinary Review Team has reviewed the case. The transfer procedure involves preparing the client for a change in caseworkers, sending the file to a supervisor at Protective Services, and holding a meeting attended by the Center staff member involved, the newly assigned caseworker and, if possible, the client.

Speech and Hearing Testing: Students at the University of Denver test the speech and hearing of all children placed in the crisis nursery. Diagnoses are made along with recommendations concerning referrals; these test results assist the social worker

in treatment planning. This service will be extended to children in other Center-sponsored treatment programs, when those programs begin. The University students are conducting a study of the speech and hearing developmental lags in abused children.

Multisdiciplinary Review: The Multidisciplinary Review Team, which serves as a mechanism for diagnostic review of Center cases, meets weekly to assess staff reports on all Center and ACDSS Protective Services' abuse intakes. The Team consists of the assistant District Attorney and representatives of the Protective Services Unit (ACDSS), Juvenile Court, the Mental Health Center and Tri-County Health, as well as the project's medical consultant and a member of the community. Because of the usually large number of cases reviewed each week, a procedure has been worked out whereby a staff summary is prepared before the meeting and the Team members provide additional comments and recommendations they consider necessary. The second activity of the Multidisciplinary Review Team is to monitor the abuse-related agencies in the community, to ensure that they are carrying out the case recommendations of the Team.

Case Management: Because the Center's caseload size has been limited from the outset to no more than five cases per worker, there has been no fluctuation since the maximum was reached in February. The Center's administration restricted the number of cases carried on a regular basis, in order to allow social workers time to deal with the large number of intakes and to set up and implement various treatments.

Treatment: Because of the large number of intakes, staff has been able to provide post-intake treatment services in only a few cases. In addition to individual counseling, adult clients in ongoing Center caseloads may receive family counseling, marital counseling, child growth and development education, and group therapy. They may also be referred to a Parents Anonymous group, one of which is sponsored by a Family Center social worker. Individual counseling and play therapy are provided to children in the project staff's caseload. Certain treatments and services that are provided by the Center have been made available to some abuse clients of ACDSS. Below are more detailed descriptions of some of the treatment services offered by the project:

> Medical Care: As mentioned previously, the project nurse provices medical examination of children during the Center's first contact with a family suspected of being involved in actual abuse. She also examines the children in the crisis nursery daily. When the project's medical consultant position was filled, this person provided further medical services to children in the crisis nursery and was on-call for any medical emergencies. Now the Adams County Medical Group is on-call for emergencies.

Lay Therapy: The lay therapy program component progressed from the planning phase to the first steps of implementation in February with the hiring of six lay therapists, each matched with an abusive parent, whose job entailed becoming the friend of this parent. The criteria used as a basis for selection of the lay therapists were the following: (1) parenting experience; (2) ability to be supportive and yet allow another person to be independent; (3) have mechanisms for coping with stress; (4) evidence of a support system; (5) ability to separate parents' needs from those of the child; (6) ability to work as a member of a team; and (7) acceptance of project sponsorship (i.e., being part of the Adams County Department of Social Services). The families assigned to the therapists all have the abused child in the home and, in each case, the parent(s), while isolated from others, asked for and accepted help.

Child Growth and Development: Eight parents were enrolled in the first six-session child management class. It met for one and one-half hours once a week and was co-directed by one project social worker and the project nurse. Child development from birth to six years was covered in the course of the class. The second class recently got underway, and plans are for the class to be a continuing resource for the county.

Crisis Nursery: The crisis nursery, which can accommodate six children at any one time, provides food, shelter and emotional support for children from dysfunctional families. Children are accepted if they are actually abused or if they come from potential abuse situations. A parent can request voluntary temporary placement of his/her child, but the actual placement must be arranged by a Center staffperson. The nursery houseparents have provided a 24-hour homelike environment for a total of fifteen children in the first six months of the nursery's operation.

VII. PROFILE OF CLIENT CHARACTERISTICS

Of Family Center intakes seen between January and May 1975, 29% were referred by school personnel, the ACDSS referred 18% and self-referrals accounted for 15% of all referrals. A little over one-half (55%) of the intakes involved actual abuse; 36% were potential abuse cases; 5% were failure to thrive; and 8% included either actual or potential neglect. More than one-half of the families in the project intake exhibited marital conflict as a primary precipitating problem leading to the abuse or potential abuse. However, there was a high percentage of intact families in intake, with 77% legally married and living together. Additional key precipitating problems for Center clients which helped explain the abuse situation were mental illness

(found in 38% of all Center families), financial difficulties (found in 39% of the families), history of abuse as a child (evidenced in 37% of Center families) and social isolation (found in 35% of the families). Other facts of note regarding the project's intakes are that the average family income, $8233, was within the range of the average family income in Adams County as a whole (i.e., $7000-$15,000 per year) and that only 8% of families referred to the Center were receiving some kind of public assistance at the time of intake.

VIII. CLIENT FLOW

Identification

The prospective client first comes to the Center's attention through referral from one of several sources; various schools and the Department of Social Services make up the highest percentage of referrals. Neighbors, relatives, and other individuals are also important sources of referrals. The calls come to the Family Center staff member on duty for that day, who takes initial information over the phone. If the call is clearly not related to actual or potential abuse, the social worker refers the caller to an appropriate community resource.

Intake

A social worker responds to every referral of suspected abuse within 24 hours of the referral. In situations that seem to be emergencies, a home visit is made immediately; otherwise the first contact with the family is as soon as possible. The social workers, under supervision, decide whether or not to ask a law enforcement officer to accompany them on an initial home visit; such a request, however, is rarely made. The worker's assessment consists of talking to the parents, and to the child, if possible, and viewing the physical and emotional environment of the home. The project nurse gives the suspected abused child a physical examination. If the child is in imminent danger, a policeman or sheriff's deputy is called, since law enforcement officers are the only ones who can remove the child from the home up to 72 hours without a court order. However, the parents may grant voluntary custody to ACDSS temporarily or take the child to a hospital or physician for a physical examination. When it is necessary to keep the child from returning home, the social worker prepares the court report required for a hearing. In determining whether the case would be appropriate for either the Center or the Protective Services Unit, the social worker checks the state's Central Registry and the Protective Services and public assistance indexes at ACDSS for evidence of any history of abuse. People associated with the family are asked to comment and to provide background information during the assessment process. If the family

needs any immediate advocacy services, arrangements are made by a Center social worker while the intake process, which usually takes two weeks, is still underway.

Referrals to the Center have averaged about 37 a month since the project began accepting cases; intakes have averaged 28 a month. The numbers began leveling off in March, when the project started sharing intake responsibilities with ACDSS. The Center, according to an agreement between the agencies, now handles the first six intakes each week and the Department handles the remainder.

Diagnosis and Treatment Planning

Near the end of the intake process, the social worker and other staff members involved will discuss the merits of the case with the Supervisor; then, based on the discussions and the primary intake person's judgment, a report is written for the weekly Multidisciplinary Review Team meeting. The Team makes comments and recommendations concerning the case report, usually concurring with the proposed treatment goals. Many of the cases referred and subsequently presented are not substantiated abuse, but potential abuse; however, the project and Adams County Department of Social Services are encouraged to provide ongoing intervention for this kind of situation. Over 90% of the Center's cases are transferred at this point to the Protective Services Unit of ACDSS for continuing treatment.

Treatment

The project provides ongoing case management, counseling and other treatment for the cases it keeps after the intake process (about five cases per social worker), and also provides treatment services for some families whose cases are transferred to the Protective Services Unit. Specifically, the crisis nursery, lay therapy services and child growth and development classes are available for both clients from Protective Services and for Center clients. All ongoing project cases that are current are reviewed and reassessed regularly with the Supervisor. The length of time in treatment depends on the client's progress, as evaluated by the worker, or on the client's meeting the conditions placed on the type of treatment provided (e.g., the child growth and development classes are limited in number, and the crisis nursery provides only a short-term stay, restricted by law to no longer than 90 days).

Termination

No specific criteria have been worked out for termination since none of the Center's cases have approached closure. A follow-up procedure also has yet to be formulated.

IX. RESOURCE ALLOCATION

The project's first year budget was about $186,000 with some $14,000 coming from community agencies in the form of actual and in-kind contributions and the remainder coming from federal demonstration funds. The total second year budget is approximately $280,000, out of which $33,000 was carried over from the first year, and $73,900 was contributed by the Department of Social Services and other community groups and agencies.

By far the largest amount of staff and volunteer time (36%) goes into the crisis nursery, although only 14% of project expenditures are for the nursery because people put in long hours and considerable volunteer time goes into it. Community activities, that is, education, coordination and policy development, take up between 4% and 8% of staff time; casework activities (intake and case management) take up 13% of staff time and 17% goes to treatment services to parents. Most of the remainder of the time is spent in project operations and research.

X. IMPLEMENTATION ISSUES

Several problems arose during the Center's first year as the new program was implemented.

Different Expectations for the New Project

Despite the fact that many different agencies were involved in designing the proposed program, it became apparent soon after award of the grant that there was a conflict in the expectations of what role the new Family Center was going to have.

Role of the Multidisciplinary Review Team

The Team, meeting regularly before the Center began, did not feel integrally linked to the new project and was not eager to come under new leadership. There was some confusion over the role the Team should play in the project's policy formulation, some members feeling that this was also part of their responsibility, in addition to diagnostic review.

Working Relationships with Other Agencies

Establishing a satisfactory working relationship with ACDSS and local law enforcement agencies has taken continuous effort on the part of Center staff.

Providing Intake Service Only

The first three months' experience, with the Center serving as the sole abuse intake unit for the county, proved that this type of approach could result in rapid response to all reports. However, the staff soon became overwhelmed by the large workload and an agreement was reached with the Protective Services Unit whereby the Center would take only the first six abuse reports per week, and the Protective Services Unit would handle the rest.

Staffing

The project's proposal did not include a Casework Supervisor and, after a few months of operation, the Director realized that she could not be both an administrator and case supervisor for a program of this size. Finding houseparents for the crisis nursery was also particularly difficult.

Use of the Crisis Nursery

The project is very proud of this program component, but difficulties have arisen in restricting both placements and length of stay.

XI. FUTURE PLANS

A significant addition to the program will be the implementation of new methods of treatment for abused children. Although the exact type of intervention has not been selected, it has been decided that most child clients will be housed in designated foster care and day care homes. The School Referral Program will be expanded in the second year to include regular visits by the district liaison person to provide feedback concerning referrals and to set up classroom programs aimed at preventing child abuse. The Center plans to expand community input into its program and plans are also underway to train volunteers to supplement the lay therapy program.

APPENDIX B

PRO-CHILD: ARLINGTON, VIRGINIA

PROLOGUE

"Although the staff of the Protective-Preventive Services Unit were providing excellent casework services to their clients, it was clear that they would benefit greatly from consultation by professionals of other disciplines and from having staff of different skills working with the project," said the Director of Pro-Child, previously the Supervisor of Protective-Preventive Services. "As part of the new grant, we decided to add a Multidisciplinary Team so that staff could bring particularly difficult or worrisome cases to an outside group of experts (lawyers, pediatricians, psychiatrists, psychologists) for review. We also hired a nurse, a homemaker, and a case aide to provide the kind of specific services to clients that the staff had felt were necessary, but they had been unable to provide previously due to lack of skills or simple time constraints. Now concrete services, such as homemaking, day care, and assistance with transportation and medical care and supervision are immediately available to our clients.

"Because child abuse and neglect are such complex problems and the effectiveness of any one treatment modality is largely unproven, we also wanted the opportunity to expand the number and kind of services which we could provide, so that the differing needs of clients could be met. The new services we've developed include group sessions with parents or children, family and couples counseling, art therapy for children and a day care program. We have also developed short term placement positions for children in several Arlington homes as an alternative to foster care.

"I think, overall, that we have succeeded in creating a greater diversity and higher quality of services to clients than would ever have been possible here, or is usually possible within public protective services departments."

I. HISTORY

In September 1972, a separate unit dealing solely with abuse and neglect problems was established within the Department of Human Resources (DHR) of Arlington (the local department of the Virginia Public Welfare Agency). A Protective Services Task Force comprised of professionals from many disciplines was developed in 1973 to attempt to resolve some of the problems related to abuse and neglect in the county. The need

felt by these Task Force participants, staff of the Protective-Preventive Services Unit of DHR, and others in the community for a more comprehensive and innovative program which utilized a multidisciplinary approach was the impetus for developing the federal grant proposal. The proposal, written by staff of the Protective-Preventive Services Unit, was primarily concerned with establishing new program components whose success had been at least partially demonstrated in other programs. The proposal also dealt with the weaknesses and gaps in the child abuse/neglect system in Arlington, particularly the lack of coordination among agencies, and the fragmentation and duplication of services. The new project, Pro-Child, was funded in May of 1974 and encompassed the existing Protective-Preventive Services Unit, including previous staff and budget.

II. COMMUNITY CONTEXT

Arlington County is a small (26 square miles), affluent suburb of Washington, D.C. Only 3.7% of the population had incomes below the poverty level in 1970, while in that same year, fully 44% had household incomes over $15,000.

The Virginia Code, prior to 1975, stipulated that reports of child abuse and neglect be reported to the Juvenile and Domestic Relations Court, the police or the sheriff's office, and that services for abused children and their families be provided by the Department of Human Resources. The resulting situation was that the Court received some reports, the police received some reports, and the Protective-Preventive Services Unit received some, but there was no way of identifying or preventing gaps and duplication of the reporting system.

Once a report was received there was, likewise, little in the way of coordinated services planning, with the court handling some cases alone, referring some to Protective Services or handling some cases jointly with that Unit. Similarly the police might handle a case independently, or refer the case to the court or Protective Services, or both. In addition to these agencies, school personnel, public health nurses, hospitals and other community agency staffs had been providing services to abuse and neglect families unknown to these three key agencies.

In 1975, a new law was passed that provides the legislative impetus for a more coordinated system. Under the new law, the Division of Social Services (Pro-Child in Arlington) is the single agency mandated to receive reports and carry out treatment planning and service provision for abuse and neglect cases. The law also provides for a 24-hour reporting hotline, which will aid inter-county coordination and provide a centralized focus for the entire state.

III. PROJECT GOALS

The goals of the Pro-Child project are as follows:

1. To develop public awareness of the problem of child abuse and neglect, by providing education in the detection, prevention, protection and care of the abused child; and to develop a knowledge of services available in the community and an understanding of the alternatives to placement of the child;

2. To identify, diagnose, and treat abusive and neglectful families, and those in high risk situations with more innovative, effective, and efficient methods;

3. To facilitate a more effective coordination and expansion of community resources for the delivery of services to abuse and neglect clients, including better defining respective agency roles;

4. To strengthen family functioning whenever possible and thereby reduce inappropriate placements;

5. To increase the medical community s awareness of suspected abuse/neglect situations, the services available, and thereby increase referrals;

6. To conduct evaluation and follow-up studies and participate in research to determine the effectiveness of Pro-Child, and to assess the implications of abuse and neglect on parents and children.

IV. ORGANIZATIONAL STRUCTURE

The project is housed within the Bureau of Family and Child Services of the Division of Social Services in the Arlington Department of Human Resources, as was the previous Protective-Preventive Services Unit. Project staff occupies a suite of offices in the same building as other Social Services Units.

In addition to the federal monies received through the new grant, the State of Virginia and Arlington County have continued to provide monies to support the protective-preventive service workers (six social workers, a supervisor, and regularly designated time of a pediatrician, attorney, and Pupil Personnel Supervisor) and other administrative costs.

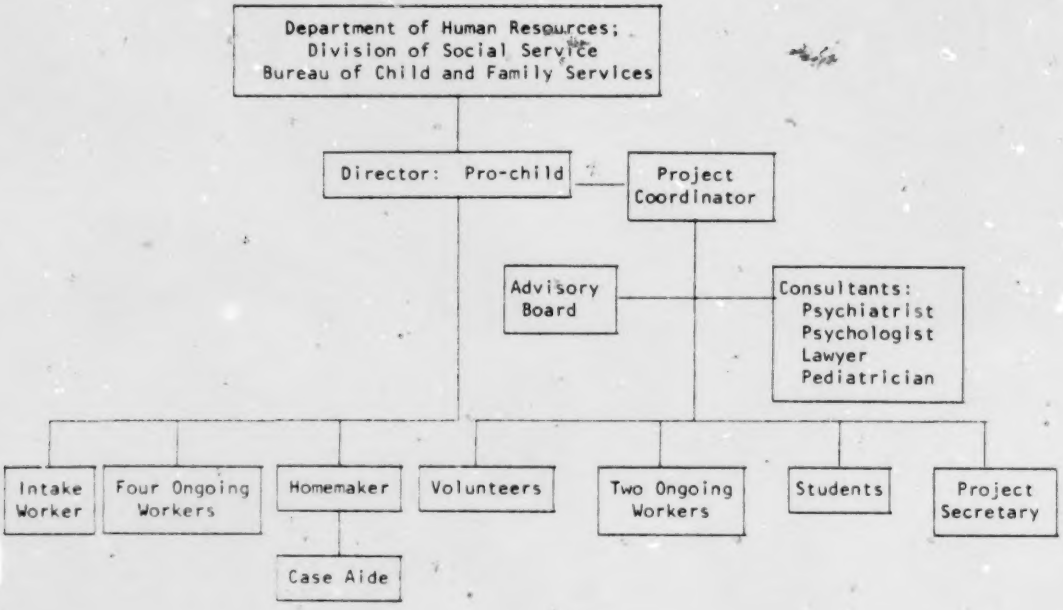
Although the project is somewhat autonomous in its day-to-day affairs because of its federal grant status, it is nonetheless subject

to all Departmental regulations and procedures, and the overall management and accountability rests with the Division of Social Services of the Department. All policy decisions and many administrative and program decisions are made jointly by the Project Director and the Chief of the Bureau of Family and Child Services within the Division of Social Services. Despite the often difficult task of operating a joint federally-locally funded project with two different foci of accountability, Pro-Child, by being housed in an ongoing community agency, has had the advantage of being readily accepted by other agencies, particularly in terms of the project's credibility and leverage within the community.

V. STAFFING PATTERN

The Pro-Child Project consists of a Project Director, a Project Coordinator, an Intake/Assessment Social Worker, six ongoing Social Workers, a Public Health Nurse, a Case Aide, a Homemaker and a Project Secretary. The organizational relationships of these staff members and their accountability both within the Project and within the Department of Human Resources is depicted on the following chart.

FIGURE 1: Organizational Chart



VI. PROJECT COMPONENTS

Community Education: In addition to providing direct services to clients, all Pro-Child staff have been involved in providing educational presentations for the community. These presentations are directed at helping citizens become more aware of the dynamics of child abuse and neglect, their reporting responsibilities, and the resources that are available in the community to combat this problem. Pro-Child staff have been interviewed for newspaper and magazine articles, appeared on local television and radio shows, distributed posters and pamphlets throughout the county, and given presentations to many groups, including service clubs, students and auxiliaries.

Professional Education: In order to acquaint local professionals with the problems of child abuse and neglect, the Virginia Code requirements related to abuse and neglect, and the services available from Pro-Child and other agencies, the project staff have held meetings, training sessions, and interviews with a wide variety of community agencies.

Most of these efforts have been aimed at professionals who are apt to come in direct contact with abuse or neglect situations, including personnel in the schools, the Juvenile and Domestic Relations Court, and hospitals, as well as police and private physicians.

Coordination: Efforts to develop a more coordinated community system, one of the goals of the project, hinge on the educational efforts described above and on extensive coordination activities with community agencies. Prior to passage of the new state law in early March 1975, the project's attempts at coordination were primarily in the area of centralizing reporting so that one agency, instead of three, would have responsibility for receiving and investigating all reports of abuse and neglect. Agreements were reached with both the police and the Court that all abuse and neglect reports would be forwarded immediately to Pro-Child for investigation. The Virginia Code now makes this reporting procedure mandatory.

Attempts to coordinate service delivery include developing procedures for referrals and follow-up between service delivery agencies, and joint consultation on individual cases whenever necessary.

Legislation and Policy: During its first year, staff of Pro-Child worked with state legislators and other agency personnel to draft a new child abuse and neglect law in Virginia. The new law, Title 63.1, passed in March 1975, designates the local department of welfare (Pro-Child) as the sole agency to receive reports. It broadens the definition of abuse and neglect, provides penalties for failure to report, and mandates 24-hour reporting and investigation coverage, the use of Multidisciplinary Teams, and the establishment of a state Central Registry. Each of these provisions was supported by Pro-Child, and the Multidisciplinary Team approach was patterned, in part, after Pro-Child's program. The Project

Director and Coordinator have been involved in the statewide task forces responsible for devising regulations to implement the law and are planning to sponsor a workshop for Arlington agencies to acquaint professionals with the new regulations.

Research: The evaluation efforts of the project have included the development of monthly statistical summaries of all cases, logs of client contacts, and other record-keeping procedures required by the Department or the state agency. Additional research efforts include an analysis of referral sources to determine the effectiveness of Pro-Child's educational efforts, analysis of client success and recidivism rates, a survey of clients to determine their impressions about the project and the services they received, and participation in two research studies conducted by social work professors and students about Pro-Child clients.

Treatment Services

Case Management and Regular Review: Each of the social workers on the staff provides general casework services for all clients in his or her caseload (approximately 25 per staff member) either individually or as a team with other staff members. Home visits, telephone calls, and office visits are all used to maintain close contact with clients.

The workers provide a supportive, non-judgmental framework for discussing the families' problems and attempting to resolve them. In the course of this casework, they assess the needs of the family and provide, either directly or through referral to other agencies, the services required. Agencies in Arlington that provide supplementary financial assistance, clothing, food, transportation, legal aid, etc., are used as referral sources by Pro-Child workers. In addition, many services are available through other units of the Division of Social Services, e.g., AFDC assistance and public health clinics, including well-baby, dental, mental health, child diagnostic and evaluation, growth and development, alcoholic and drug abuse clinics. Follow-up on referrals is usually provided.

Each worker reviews his or her ongoing cases at least once every three months. At this time the client's progress is assessed, any new problems are explored, and if warranted, new goals and treatment plans for the client are established. Less formal, ongoing review of cases takes place with each worker's supervisor on an as-needed basis.

Court Case Activities: Staff social workers who are faced with the need to present a case in court are given legal counsel by the lawyer who is a member of the Multidisciplinary Team. The County Attorney's Office has donated 20% of this lawyer's time to the project.

The social workers prepare the necessary petitions with assistance from the lawyer, explain all of the proceedings to the parents and child, and appear in court to testify and make recommendations about disposition

of the case. They then provide the necessary assistance in implementing whatever decision has been reached by the court. If a case requires foster care services, Pro-Child usually continues to work with the family while the child is in care, in order to effect early family reunification.

Psychological Testing: Psychological testing of both adults and children is provided by the psychologist who serves as a consultant to the project and is a member of the Multidisciplinary Team. His interpretation of the tests administered is aided by his thorough knowledge of the types of cases Pro-Child deals with. His continuing availability to workers for consultation helps provide more appropriate treatment planning.

Multidisciplinary Team Review: Multidisciplinary Team reviews of complex or problem cases are held on a bi-weekly basis. Two cases a session are usually reviewed with all staff and consultants, including a pediatrician, psychiatrist, psychologist, lawyer and a school representative. In addition, other professionals who have direct knowledge of a case, for example, a Public Health Nurse or School Social Worker, are often asked to attend these meetings. The meetings are held both to enable an individual worker to better deal with a specific case and to provide continuing education and exposure to a variety of problems for the remainder of the staff.

Individual Therapy and Counseling: The treatment mode most frequently used by Pro-Child staff, either alone or in conjunction with other services, is individual therapy or counseling. Through this technique, the staff attempts to engage clients in a dialogue that permits the client to explore his or her feelings about problems he or she is encountering, to analyze various solutions to the problems, and to choose a course of action suited to achieving his or her desired goals. This counseling usually takes place in the client's home or the Pro-Child offices, as often as necessary, and is not limited to strict "appointment" times. The counseling tends to be intensive when a client first enters the project and around crisis periods, and gradually tapers off as clients become more able to cope with their problems.

Group Therapy: Three staff members co-lead group therapy sessions for many Pro-Child clients. There are currently afternoon and evening mothers' groups and an adolescent group; each has approximately 10 participants. Two of the social workers are also jointly offering family therapy sessions for a few of their clients and this component may be expanded if it appears effective over time.

Day Care: During its first year, Pro-Child provided day care for up to 15 children one day a week through a contract with the local YMCA. The primary purpose of the WAY program (Wednesday at the Y) was to give the parents some relief from their daily child care responsibilities and to provide an opportunity to assess the developmental difficulties of

the children. The children were provided with a variety of learning experiences, went on field trips and had structured play time.

The WAY program has been discontinued, but the project is currently negotiating with another church affiliated organization to provide the same type of day care for an expanded number of children.

Special Family Care Homes: Pro-Child has four Family Care homes for the temporary day and over-night care of children. Three of these homes take children of all ages for short periods and one home works only with adolescents. One of the homes for younger children is subsidized by Pro-Child, so that there is always at least one slot held open for real emergencies. The other homes are reimbursed, based on the number of days and nights a child is in care. These homes are particularly appropriate for situations where brief child care is needed, e.g., a family crisis requiring a "cooling down" period or a temporary hospitalization. The only alternative would be foster care, which tends to involve temporary loss of custody and is a threatening experience for parents.

Play Therapy: An Art Therapy class for up to six children is provided once a week by a trained art therapist. These classes provide a mechanism for the improved diagnosis of children's psychological problems and provide the children with an acceptable way of expressing themselves.

Homemaking Services: Homemaking services, including assistance in household management, budget preparation, and nutrition counseling, are provided for many clients by the project's Homemaker.

Medical Care: The Public Health Nurse who is a member of the staff does medical screening and provides nursing services and routine medical services for parents and children when required. In addition, many other forms of medical care are available to Pro-Child clients through clinics and special programs operated by the Department of Human Resources.

Transportation: County cars are available to the Case Aides and other staff to provide clients with transportation to shopping areas, medical and other appointments, Pro-Child activities, and the day care program. In addition, the three staff members providing group therapy supply participants with transportation to and from these sessions.

Financial Support: A modest amount of money is available, partly through the grant and partly from private donations, to make small loans to clients in a financial crisis. Food, clothing and other supplies are also given to clients who are in need.

VII. PROFILE OF CLIENT CHARACTERISTICS

Most Pro-Child cases accepted during the first year (33.7%) were referred by the schools. Acquaintances, other agencies, and parents also referred a large proportion of cases. There were more neglect cases accepted than abuse cases, and both abuse and neglect cases tended to be moderate/mild or potential cases of the two problems. Parents were generally Caucasian, in their 30s, and had fewer than three children in their families. Most parents (73.4%) were legally married or divorced/separated. Over 60% of both males and females had at least a high school degree. Almost 80% of the males were employed full-time; a substantially lower proportion of females (37%) had full-time jobs, and almost half (49%) were unemployed. The average family income was $9938, but fully 47% of the families had incomes over $10,000, reflecting the upper-income suburban class nature of the county. Marital problems, mental health disorders, financial worries and heavy child care responsibilities were the primary problems most often cited as contributing to the abuse/neglect problem. There were no deaths or severe abuse/neglect reincidence while cases were in the caseload. Moderate to mild abuse and neglect occurred occasionally (21.4% of the cases) and both emotional abuse and neglect occurred in a larger proportion of cases (36%).

VIII. CLIENT FLOW

Identification: Referrals during this first year were initially received by the Department of Human Resources Generic Intake Unit, which screened cases for referral to the appropriate DHR Unit. Some preliminary information was recorded by the Generic Intake Unit staff and if the complainant alleged abuse or neglect, or there appeared a serious potential for abuse or neglect, the case was referred to Pro-Child.

Intake: Cases received from the Generic Intake Unit are logged in and assigned either to the Intake Worker for preliminary assessment, or to an ongoing worker if the case has been known to an individual worker previously, or if the Intake Worker has too many cases already.

The Intake Worker makes a series of home visits to assess the home situation, the primary problems contributing to the abuse or neglect or potential abuse situation, and the client's motivation for accepting services. Collateral contacts are made with other people or agencies who know the family in order to gather as much information as possible. If a report is invalid, or the persons involved cannot be found, the case is closed. If a report is inappropriate for Pro-Child, but the family has other problems, a referral is made to another agency or to a unit within DHR. For those cases that require only minimal service to help the family maintain stability, the Intake Worker herself will often provide the necessary services for a few weeks and close the case. If, in the Intake Worker's judgment, the family will need ongoing services and

support, she completes the family assessment, develops an initial problem diagnosis and presents the case to the full staff for assignment to an ongoing worker. Cases are assigned to ongoing workers based on both a staff person's desire to work with the case and on an attempt to maintain an overall equal distribution of cases among staff.

Diagnosis and Treatment Planning: The process of diagnosis and treatment planning, which begins at Intake, continues through the first few meetings that the ongoing worker has with the client. The worker will ascertain more fully what the problems are and what services the client feels would be most helpful. The worker helps motivate the client to discuss his or her feelings and problems more fully and to agree to continued intervention by the project. Through consultation with his or her supervisor, outside agency personnel (if appropriate), and the project's consultants, the worker will formulate a treatment plan and present it to the client. If necessary, psychological or other tests will be administered to parents or children, or both. Particularly complex or problematic cases may be presented to the Multidisciplinary Team for a shared diagnosis and treatment plan formulation.

Treatment: Those services that are most appropriate to the client's needs, and which he or she is able to accept, are provided either directly by the project or through referral to other agencies. Continuing contact is maintained with other agencies, usually teachers or other service personnel who know the client, in order to assess progress or the development of new problems. Cases are reviewed every three months and new goals and treatment plans may be established. A case may be reviewed by the Multidisciplinary Team any time a worker feels the need for additional input or is worried about the unsatisfactory progress of a case. Each of the consultants is also available for individual conferences about particular cases during the weeks the Team doesn't meet. Services for both parents and children are provided as long as is necessary to promote adequate family functioning.

Termination: Specific termination criteria have not been developed, but normally a client remains in treatment until the family situation has stabilized and the worker feels confident that there is minimal or no danger to the child and that the parent can no longer benefit from services. Many times clients will move from the area or will refuse further services, which, unless there is enough evidence to bring the case to court, also results in termination. There is currently little follow-up on terminated cases, but the project is working to develop specific procedures to periodically check on the progress of these former clients.

IX. RESOURCE ALLOCATIONS

Pro-Child's budget for its first year operation was $208,170. Federal funds accounted for $102,085 of that amount; the remainder was allocated to the project from county/state funds. The resource expenditures of Pro-Child have remained fairly constant during the first year of project operations. In May 1975, which was a typical month for the project, the largest percentage expenditure was for case management and review (21%), highlighting the project's emphasis on direct services to clients. Other areas of heavy expenditure were Individual Counseling (12%), Intake and Initial Diagnosis (9%), General Management (9%), and Staff Development and Training (7%). The remaining 62% of the project resources were expended among the remaining 25 project components, both project oriented (e.g., program planning, evaluation, research) and direct services (e.g., group therapy, day care, transportation), but in no case did any of these components consume more than 6% of the resources.

The resource expenditures of each component correspond very closely to the actual amount of time spent by staff on that component, emphasizing the fact that the primary cost of most service components is a staff salary cost.

X. IMPLEMENTATION PROBLEMS

Staffing: Because the project is housed within a public agency, the hiring of staff must proceed through official civil service channels, which often holds up actual hiring for weeks or months. This has hampered efforts of the project to fill existing slots on many separate occasions.

Multidisciplinary Approach: It has been difficult for some social work staff to adjust to the concept of working as a team with other staff who are not social workers. There was considerable confusion about the roles and responsibilities of new staff (Public Health Nurse, Homemaker, Case Aide, Parent Aide), and there were problems in determining the proper role for all staff in cases where other professionals were simultaneously involved with a family, e.g., other public health nurses, psychiatrists, probation officers, staff of other agencies.

Criteria for Acceptance and Termination of Cases: In order to maintain a manageable caseload, and to preclude the acceptance of cases essentially inappropriate for Pro-Child (e.g., no actual abuse or neglect), the staff were forced to define a set of criteria for accepting cases into the project, with highest priority given to cases where a recent incident of abuse or severe neglect has occurred. In order to eliminate the common practice of keeping cases open on a "maintenance only" basis (i.e., periodic contact with a relatively stable case), the project will also shortly be defining termination criteria.

Development of 24-Hour Services: The issue surrounding development of 24-hour coverage was whether, and how much, the staff who were on call seven days a week should be compensated for their time, an issue which has not yet been fully resolved even though the state law now mandates that service. For projects housed in public agencies, it is clear that implementing programs that require changes in personnel or staff payment procedures can be very complicated, since it is difficult to introduce changes for one unit that are not applicable to other units.

Coordination with Other DHR Units: Because the project concentrated originally on developing relationships with outside community agencies, rather than with other DHR units, and also, in part, because of the feeling among other DHR staff that the project, by virtue of its federal grant status, was able to provide more services, there have been some strained relationships between the project and these units. Since many of Pro-Child's clients require services provided by these units (foster care, adult services, AFDC assistance, etc.) the project is now attempting through meetings and educational presentations to develop better working relationships with all DHR units.

XI. FUTURE PLANS

During the second year, a new Intake Worker will be added to the staff and the project will assume its own initial intake of cases. A new day care program, with an expanded capacity, is being developed through an agreement with a church-affiliated organization. Twenty-four hour referral services will be made available to the community through an arrangement with both state and local hot lines. Some additional group and family counseling sessions will be developed and a home that will accept a mother and her child for short periods of time will be supported.

APPENDIX C

ARKANSAS CHILD ABUSE AND NEGLECT PROJECT: LITTLE ROCK, ARKANSAS

PROLOGUE

On my first visit to the SCAN project in Arkansas (the letters stand for Suspected Child Abuse and Neglect), I had witnessed many of the supportive layers of the organization, which enable the core of the system, the lay therapy model, to operate unencumbered by administrative or programmatic responsibilities. I'd listened to the project staff of SCAN recount their progress and problems in the communities in Arkansas where the demonstration project is funded. I'd interviewed community agency representatives for their perspective of the role the project played in the service network for abusive parents. I'd visited a SCAN day care center and attended an evening session of Parents Anonymous, sponsored by SCAN. I had read case file notes of active clients. And I'd been along on the initial evaluation of a distraught young mother whose child had been removed by court order for necessary medical attention. The SCAN worker had tactfully and supportively elicited from her a tale of isolation, excessive home responsibilities, and low self-esteem, all of which are consistently present in an abusive or potentially abusive parent, and are known to project members as the "dynamics of abuse."

Now, the SCAN staff was collected in the conference room of an old Georgian-style brick building on the V.A. Hospital grounds for its semi-monthly staffing. Since the essence of the SCAN project -- the actual relationship between an individual lay therapist and his or her client -- is private rather than public, this staffing promised to bring an outsider as close to experiencing this relationship as possible. It was not a disappointment.

In the course of the four-hour staffing, the real core of the lay therapy model became visible, as the workers recounted their efforts over the preceding two weeks with the two or three clients to whom they had each been assigned. In this session, the capacity of the team members to help each other resolve frustrations and confirm perceptions of progress in their cases was readily apparent. It was particularly illustrative of the techniques they use with their clients. While there is an ever-expanding list of activities which the lay therapist undertakes in an effort to help a client (such as providing information about available services and programs, providing on-the-spot counseling in marital relations, sex education, and child development; providing a parenting model; providing transportation or babysitting to enable the parent to attend PA; or even supplying emergency funds for food), the workers

prefer to think of their basic responsibility to their clients in terms of friendship -- non-critical, non-judgmental, non-punitive friendship. It is this climate of support that was apparent in the staffing and that enables the client to transform a negative self-image, accept discipline alternatives to abuse, and ultimately to gain a level of stability and independence.

I. INITIAL CONCEPT OF THE PROJECT

Following the passage of the child protection legislation by the Arkansas legislature in 1967, the rate of reporting of child abuse and neglect cases to Arkansas Social Services began to increase. As the Social Services staff strained to provide adequate service to the growing caseload, it became apparent not only that additional resources would have to be committed to child protection, but that some new kind of community system would be needed to counter the apparent increase in incidence of abuse. Key to following the serendipitous fashion in which the Arkansas system for child protection evolved is the recognition of two independent and parallel efforts which were brought together by an abusive mother.

One side of the history begins with the Pulaski County Task Force for Child Abuse. While the Task Force moved forward, with the help of Dr. Ray Helfer, to explore the available models for child protection, an informal effort was independently taking place which would ultimately lead to the creation of a workable system of volunteer service delivery to families in which child abuse had occurred.

In the summer of 1971, Sharon Pallone began working with an abusive mother as a volunteer lay therapist. In the course of events, Dr. Young, the Chairman of the Task Force, also worked with the woman, thereby becoming aware of Ms. Pallone's approach. Since the volunteer group concept resembled the model that had been proposed to the Task Force, Ms. Pallone was encouraged to recruit additional volunteers who were then trained by Dr. Young, Ms. Pallone, and Social Services. By the summer of 1972, the group of volunteers had established a non-profit corporation, SCAN (Suspected Child Abuse and Neglect) Volunteer Services, Inc., and had been contracted by Social Services to offer treatment services.

In time, as the caseload and lay therapy staff grew, and SCAN gained credibility within Arkansas Social Services, local task forces were formed in other counties of the state where public interest in the formation of SCAN units was fostered. By the fall of 1973, SCAN was operating local units in three additional counties. At this time, members of the staff at the University of Arkansas Graduate School of Social Work became aware of the availability of demonstration funds in the field of child abuse and approached SCAN and Arkansas Social Services to develop a proposal. The program, which was federally funded in the spring of 1974

for three years, involves three local SCAN units working in consort with Social Services Coordinators in each county, who have the responsibility of facilitating the delivery of services provided by the county to SCAN clients. Management of the multi-county project takes place in the state offices of Arkansas Social Services and in the central SCAN office, both in Little Rock.

II. COMMUNITY CONTEXT

Demographically, the three demonstration sites of the Arkansas project are similar. Each county has a single major town of under 100,000 population, and in each of the counties most of the people live in the major town. In other respects, however, the sites are unique and present different challenges for the local projects. The most important town in Garland County is Hot Springs National Park, a spa, resort and racetrack town. About one-third of the permanent population is over the age of 65.

In Jefferson County, the major town is Pine Bluff, located south of Little Rock on the Arkansas River. The population of Pine Bluff has declined since the last census.

Washington County is the second most populous county in Arkansas after Pulaski County (Little Rock). It is also the fastest growing county in the state. Most of the people live in Fayetteville and Springdale. Fayetteville is the home of the University of Arkansas and attracts light industry and service industry, as well as mobile upper-middle-class and professional families from many parts of the U.S.

The community system for dealing with cases of child abuse and neglect is similar in the three demonstration counties, with a few minor exceptions. Before SCAN, some cases that were discovered by citizens in the community were reported to several different agencies, and cases discovered by members of the agencies were reported at least to Social Services and sometimes to another agency. Many cases were simply not reported. The main community agencies that provided services for families in which child abuse or neglect had taken place were Social Services and the Juvenile Probation Department of the court. For cases that were not referred to Juvenile Court, the services mostly amounted to crisis intervention, temporary shelter for the child and some counseling and advocacy by counselors in Social Services.

The establishment of a SCAN unit in the three demonstration counties and the efforts of the project have changed the community systems in several significant ways. Reporting, for example, has become more centralized. Neighbors, relatives, and other citizens who previously reported to any of several other public agencies have responded to SCAN publicity and now report directly to SCAN. Other public agencies have also agreed to forward reports that they receive directly to SCAN. The

presence of SCAN also means that an additional service, lay therapy, is available for the families in which abuse has occurred. In addition, the system now includes a provision for the regular review of cases by a multidisciplinary group of consultants. If a case is a hospital case, it is reviewed by the multidisciplinary hospital team. The presence of SCAN increases the staff resources in the community that can be devoted to investigation of reports; consequently, all appropriate reports are evaluated in the family's home, and periodic follow-up after a case is stabilized is a routine part of the community system.

III. PROJECT GOALS

The following are the current project goals:

Overall Goal Statement: Because the Arkansas Division of Social Services is committed to improving the quality of the family relationship so that a child can be safe in his or her own home, it proposed to continue the demonstration of the feasibility of the volunteer model, in which lay therapists provide protective services for children and families involved in the problem of abuse and neglect.

Objective 1: Identify, develop, expand, contract for and coordinate county-wide resources necessary for more effective SCAN/Social Services operations.

Objective 2: Implement the coordinated efforts of public agencies, private agencies, and volunteer groups by providing specific services on behalf of clients.

Objective 3: Ensure immediate delivery of services to project clients and encourage other agencies to accept and provide services to project clients on a more immediate basis.

Objective 4: Educate the project community, including professionals, about the dynamics of abuse and the necessity of reporting as required by state law.

IV. ORGANIZATIONAL STRUCTURE

The most notable feature of the Arkansas project's organizational structure is its unity and cohesion, despite the fact that it is dispersed among four different cities and in two separate offices in each city. In each of the three demonstration counties there is a separate local SCAN office, housing the SCAN staff, and a Social Services Coordinator, located in the county offices of the Division of Social Services.

In Little Rock, the project headquarters are in the State Department of Social Services, and SCAN headquarters are on the grounds of the Arkansas State Hospital.

The D/HEW demonstration grant is housed within the Division of Social Services with subcontracts to the Graduate School of Social Work and SCAN. At project headquarters a management information system is maintained, containing monthly client data. Day-to-day decisions, needed for the refinement of the interaction between SCAN and Social Services, are made here. Management consultation is provided by the Graduate School of Social Work, which furnishes this service to numerous social projects in Arkansas.

While the Arkansas Social Services is ultimately accountable to the state office for providing protective services, it can, through contract, delegate duties for child abuse cases to SCAN Volunteer Services, Inc. The local Social Services Coordinator plays the dual role of speeding the provision of services to SCAN clients who are receiving social services from the agency and of ensuring that reported child abuse cases get the attention legally required by the state. Although paid as staff members of the project, the coordinators retain their status as staff members of the local Social Services divisions.

The local SCAN staffs are supervised by the central SCAN staff (in Little Rock), which in turn coordinates with the project headquarters staff. While payment for project expenses are made from the grant, the essence of the program is the use of volunteer services, both lay and professional, for service delivery and consultation to the project. In addition, some office space is donated for project use, as well as a field communications system for the central SCAN staff.

V. STAFFING PATTERNS

Figure 1 is a diagram of the Arkansas project organization. The organization contains only one formal chain of command, that within the SCAN organization connecting SCAN headquarters with the local SCAN units and the lay therapists; the rest of the project organization operates by cooperative agreements. The Social Services coordinators work within the organizational framework of the local Division of Social Services. Written procedures have been developed by the project for coordination between the Social Services coordinators and the local SCAN directors. The Project Director works within the organizational framework of the State Office of Social Services and, in fact, spends half-time with that organization, with his salary paid by them. The Project Management Consultant and her assistant are currently paid a full-time salary by the project and receive some direction from the Graduate School of Social Work. The Management Consultant takes care of the day-to-day monitoring of the project, short-term problem solving and technical assistance for

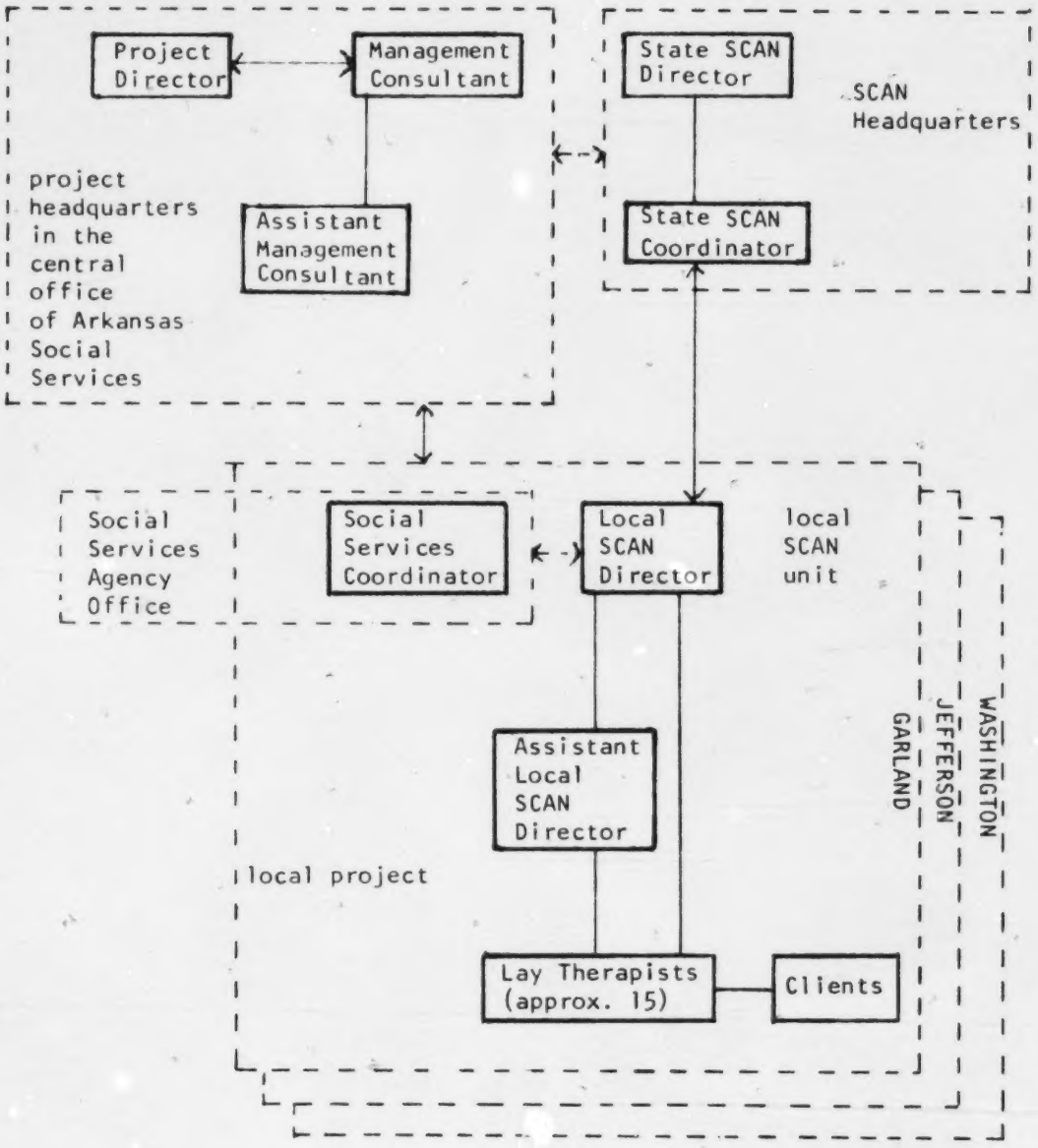
the local projects in the demonstration counties. Together with the Assistant Management Consultant, she also maintains the information flow into and out of the project and the flow of internal management information.

The State Director of SCAN, Inc., deals with the overall policy development for that organization and with the overall coordination of SCAN with Arkansas Social Services. She supervises the operation of SCAN state-wide and is available for consultation on all abuse and neglect cases. SCAN Volunteer Services, Inc. has a Board of Directors that develops policy for the organization. The State SCAN Coordinator provides the day-to-day supervision of the local SCAN directors and directs the "staffing sessions" that each project holds every two weeks.

The key to successful case management at the local level is the effective coordination between the SCAN Director and the Social Service Coordinator. The Local SCAN Directors are primarily concerned with the evaluation and initial disposition of new referrals to the project and with case management of the SCAN cases in their communities. They supervise the work of the lay therapists, provide some individual counseling to clients, provide support and back-up for the local chapter of Parents Anonymous, and devote time to community education and the coordination of community services. They work in tandem with the Assistant SCAN Directors. The Social Service Coordinators are responsible for expediting and facilitating the delivery of services from the Division of Social Services to the SCAN clients who are to receive them. The Coordinator works in close cooperation with the SCAN director on the development of case plans and participates in case reviews both at the SCAN staffing sessions and at meetings of the hospital review team. In addition, the Coordinator keeps the Social Services records for SCAN cases, assists in the development of foster homes and arrangements for day care, and shares the load of speaking engagements with the Director.

The Lay Therapists make themselves available for accepting cases assigned to them by the SCAN director. They sometimes participate in the initial investigation of a case during intake and then begin their lay therapy on an intensive basis when they are assigned to the case. Their hours are flexible, but they are on call to the families they are working with 24 hours a day, 7 days a week. The lay therapists are reimbursed for up to $50 of their expenses per month and are considered volunteer staff members. This reimbursement is a critical consideration in the lay therapy model, in that, depending upon the personal financial situation of the volunteer, the $50 monthly budget may offset any disadvantages they may experience in volunteering. Turnover among the lay therapists has been very low, usually occurring only when a lay therapist moves from the community or when there is a change in the lay therapist's own family situation. Many of the lay therapists have college degrees, and some have been trained in or have worked in various professions which help them in their work and add to the effectiveness of the bi-weekly case reviews.

Figure 1: Organizational Chart



VI. PROJECT COMPONENTS

The project components have evolved somewhat from the model that had been proposed to the original task force.

Education: The project provides public education, professional education and training for the lay therapists. The public education provided by the local projects takes place mostly in the form of various kinds of speaking engagements with schools, community groups, and other groups in the county. The presentations are made mostly by the SCAN Director or the Social Services Coordinator, but the new assistant SCAN directors are expected to provide some of this information as well. Occasionally, lay therapists and SCAN clients participate.

The project responds to professional groups that request information and also seeks out professional groups, such as the police, who should be informed of the project's position in the community and the nature of the child abuse problem.

At the headquarters level, staff members furnish public education programs with a wider scope, including speaking engagements throughout Arkansas and out of state, dissemination of a packet of informational material that can be sent in answer to written requests for information, and broad circulation of the monthly project newsletter, FOCUS, which is intended primarily for the eight project offices, but which is sent to a variety of other groups and agencies.

An integral part of the operation of SCAN is the recruitment and training of lay therapists. The lay therapy training session in Little Rock runs for three days and is very intensive. The training sessions take place two to three times a year and are generally scheduled to accommodate the volunteers who are waiting to begin. In the second year of the project, the SCAN training sessions will continue to be open to other members of the community besides lay therapists.

After the initial training session, the lay therapists continue to receive training in the form of the guidance given them during the bi-weekly training sessions, and also attendance at special seminars on selected topics several times a year.

Treatment: The SCAN units principally offer crisis intervention and lay therapy as treatment services. The local staffs have also organized Parents Anonymous chapters, multidisciplinary teams, and hospital committees in the demonstration counties and provide continuous support for them. Within Parents Anonymous they arrange for volunteers to be on hand to care for children while their parents are in the session; they provide transportation to the session when it is needed; and, above all, they provide the patient and sensitive coaxing, sometimes extended over several weeks, that is needed to get some parents to attend Parents

Anonymous. Through Arkansas Social Services the local projects also make day care and foster care services available.

Lay therapy counseling is the name given to a complex set of responsibilities. The prime task of the lay therapist is to establish a trust relationship with the client. From this basic therapeutic friendship, various hats are assumed by the lay therapist, such as that of a parenting model; marriage, sex education and/or child development counselor; as well as that of a resource and advocate for needed auxiliary services, including homemaking, babysitting, day care and transportation. In assuming any and all of these responsibilities, the lay therapist strives to maintain a non-judgmental, non-punitive relationship with his or her clients with the end goal of enabling the parent to reach discipline alternatives to abuse and to achieve independence.

Crisis intervention is a distinct service of the project and an integral part of the lay therapy. Sometimes a case is initiated through SCAN's intervention in a crisis situation that is reported to the project. Once a case has been accepted by SCAN and a lay therapist is assigned, the lay therapist is "on call" to the family 24 hours a day. Follow-up, which was also originally planned as a distinct part of the project, is now built into the lay therapy service in the sense that cases are not closed, but rather stabilized, and the lay therapist continues to keep in touch with the family from time to time to assess its ability to function independently.

Auxiliary Services: The original auxiliary services included coordination, day care/foster care, case management/advocacy and SCAN training. These services are included in the two main components of the project. Part of the treatment coordination efforts of the project have been directed toward the development of day care and foster care services in the community. The local SCAN directors have promoted day care programs and Social Services has encouraged creation of new foster homes. Case management is an underlying service provided, in the Arkansas project, by both SCAN and the Social Services Coordinator. Therefore, two files exist for any family that is receiving both SCAN services and services from or through the Division of Social Services. Advocacy is provided by the lay therapists, and SCAN training is considered a part of the education component.

VII. PROFILE OF CLIENT CHARACTERISTICS

Since SCAN was already operating in the demonstration counties when the project began, there was already a caseload and a modest number of new referrals to the project in the first month. The following client profiles are based on those families in each county with intake forms during the period of January through June, 1975.

Of the nine Garland County cases, more than half are established abuse cases, with most being moderate or mild cases of physical abuse. The average number of children per family is two; parents are relatively young (most being under 25); and all are legally married couples. All but one family are Caucasian. Almost none of the parents has had any education past high school. The average total family income is approximately $5400, with over one-quarter of the families receiving public assistance. The primary problems which help explain the abuse or neglect incident bringing these cases to the project's attention include financial, social isolation, job related and marital problems. Some reincidence is seen, in the form of emotional abuse with occasional moderate or mild physical and emotional neglect.

In contrast, proportionately fewer of Jefferson County's 28 cases are established cases of abuse or neglect. In close to 50% of the cases, however, there is a strong indication of abuse. Very few of the cases are severe abuse or neglect. The parents are slightly older than in Garland County and the families are slightly larger. Fewer of the cases are legally married couples (80%) and fewer of the cases are Caucasian (75%). The educational level is approximately the same; the average family income is higher ($7300) and more of the parents are employed, leading to fewer recipients of public assistance. The most frequently cited problems in these cases include financial, marital, and mental health. The reincidence rate is higher, reflected primarily in emotional abuse and neglect with some moderate and mild physical abuse occurring.

In the 18 Washington County cases, even fewer are established abuse, and none are severe abuse or neglect. The family size and parents' ages are comparable to Jefferson County; however, significantly fewer are legally married couples (67%). The educational level is somewhat higher than in the other two counties, as is the overall proportion of employment, but the average total family income is lower ($4800). The primary problems most often mentioned as related to child abuse and neglect include heavy child care responsibility, financial and marital problems. Reincidence is primarily seen as mild physical or emotional neglect, with some instances of moderate physical or emotional abuse.

VIII. CLIENT FLOW

Identification: Almost all referrals to the project come by telephone, from other agencies in the community, particularly Social Services and the Juvenile Court, and from neighbors, relatives, anonymous callers and self-referrals. A referral to the project is taken by the local SCAN Director or, if she is out on a case, by the Assistant Director or the Secretary. For all reports, the SCAN Director calls the Social Services Coordinator to find out anything that Social Services

may have in their records about the case and then prepares for the home evaluation. At this time a report is sent to the Central Registry.

Intake: All cases are evaluated by the local SCAN staff within 48 hours, but crisis cases are evaluated immediately, regardless of the time of day or night. During the evaluation, the SCAN Director takes a non-threatening position with the family, offering help and trying to get the family to accept SCAN services. If there is any reason to suspect that abuse might have occurred or be potential, a lay therapist will be assigned and begin visiting the client at once. If the initial evaluation indicates that the case is a neglect case, it is reported to Social Services and referred to the appropriate agency.

Diagnosis and Treatment Planning: Once the evaluation has shown that there has been abuse or severe neglect, or that there is potential for it, the case is entered in the SCAN caseload and begins to be reviewed at the bi-weekly SCAN staffing sessions. A preliminary case plan is made by the local SCAN Director and the lay therapist, with assistance from the State SCAN Coordinator and the Social Services Coordinator in some (i.e., severe) cases, to provide any immediate services beyond the lay therapy, such as day care or counseling, which need to be arranged through Social Services. Besides the reviews at SCAN staffings, the case will be reviewed by the Multidisciplinary Team at the hospital if it is a hospital case or a particularly serious case, and possibly by the community consultation team in the counties that have one. The progress of treatment is subsequently reviewed as needed.

Treatment: The main service offered by the Arkansas project is lay therapy, which takes place during visits to the client's home. Depending on the severity of the case or the degree to which it is stabilizing, the intensity of the lay therapy counseling provided may vary widely. Typically, a relatively new, difficult case receives considerably more than the average six hours of lay therapy counseling per month. In general, the lay therapists strive for some form of weekly contact with their clients. In addition, clients may receive individual counseling or participate in Parents Anonymous.

Follow-Up: As a case stabilizes, which may be six months or more after the initial referral, the intensity of lay therapy will normally taper off from several visits a week to a much lower frequency. The project continues to maintain contact with the client indefinitely, however, and keeps the client's file open, though in a stabilized status. The case continues to be mentioned from time to time during staffing sessions and during the diagnostic review team meetings. In this way, SCAN is in a position to resume more intensive treatment as soon as there are signs of need for it. If an unstabilized client moves from the county or state, the case is referred to the appropriate agencies.

IX. RESOURCE ALLOCATION

The total first year federal budget for the project was $150,000. Because the Arkansas project makes such extensive use of volunteer time in treatment services to parents, the allocation of funds by the project to the service components differs considerably from the allocation of hours. The use of volunteers in treatment and support services shows up as a higher percentage of hours than of dollars for those groups. The difference is balanced, of course, by the percentage of dollars being greater than that of hours in project operation, which is done mostly by paid staff. Aside from the fixed general administration costs, staff development was the dominant component of project operations.

Most of the staff development time is "spent" by regular staff. The main forms of staff development are regular staff meetings, project seminars, SCAN training, visits to training seminars or institutes by project staff, training provided within the project by the State SCAN Director, Project Director or Project Management Consultant, and workshops held by Arkansas Social Services.

X. IMPLEMENTATION ISSUES

The Arkansas project has had few serious implementation problems. As the project entered its second year, however, some issues now appear to be inherent in this kind of model in which a volunteer service is provided in cooperation with a county Social Services Division.

Legitimacy: Since the Division of Social Services carries the legal responsibility for providing protective services, some individuals and agencies in the community questioned whether SCAN, as a private non-profit corporation, could be accepted as a legitimate agency for satisfying the legal mandate. The project staff feels that its model could have had a better start in the community if they had prepared a circular that clarified the legal position of the private group and reassured those concerned about it by including signatures of appropriate officials.

Credibility: There was, as well, the matter of legitimacy in the broader sense of gaining acceptance by other agencies as a dependable and effective group. SCAN's efforts to establish credibility with other agencies and thereby gain their confidence and support were dependent upon their consistent demonstration of capability.

Confidentiality: During most of the first year the local projects were at a slight disadvantage in diagnosing and reviewing cases of clients who were receiving treatment elsewhere in the community. The confidentiality agreements between clients and the community mental health centers or private counseling services precluded the sharing of information about clients there with SCAN. In one of the communities,

arrangements have been made for sharing this information if the client gives his or her written consent.

Cooperative Procedures between SCAN and Social Services: Since the Social Services Coordinator works within the organizational structure of Arkansas Social Services and occupies office space there while working closely with the SCAN Director for the project, it is essential that priorities and procedures be established to ensure efficient joint decision making. During the first year, written procedures were developed as they were requested, and the project headquarters has re-emphasized them periodically, especially at the time of turnover in the position of Director or Coordinator. Beyond this, however, it has been necessary to gradually define the Coordinator's position more and more clearly with the local Division of Social Services in order to develop a clear chain of command and distribution of responsibilities. This is an important part of the development of the model whose demonstration is the overall goal of the project.

Lay Therapist's Administrative Work: The principal service of the project is lay therapy, provided by volunteers who receive only a maximum compensation of $50 a month for expenses. The concept of lay therapy as an effective service involves an element of informality, i.e., a therapeutic friendship between the client and someone else in the community who does not represent authority or the threat of punitive action. For both of these reasons it is important that the lay therapists be as unencumbered as possible with administrative duties and paper work, and the project felt that the lay therapists could not be asked to do a great deal of extra administrative work. This matter was settled by getting additional staff positions -- first, an Assistant Management Consultant at project headquarters who travels to the demonstration counties to get the needed information and second, an Assistant Director for each SCAN office. The assistant directors were already needed to absorb some of the growing workload of the directors, and the addition of the evaluation work necessitated a full-time position.

Physical Dispersion of the Project: The project operates in four different cities and in two different offices in each. The State SCAN Coordinator travels to each demonstration county every two weeks, which helps to keep the local projects in touch with each other, and the State SCAN Director and project headquarters staff make occasional visits to the local projects. This does mean, however, that meetings always imply extensive travel time, which must be taken from time that staff members could use for some other purpose. The Centrex telephone system makes it possible for the various parts of the project to have frequent telephone contact, and the project initiated in the spring of 1975 a monthly newsletter, FOCUS, which summarizes the month's developments for all members in the project. It is felt by the project staff that provisions, in the form of centralized and coordinated communication, as well as through funds for field contact, must be made to accommodate physical dispersion.

XI. FUTURE PLANS

The project has spelled out most of its future plans in the objectives of its second-year proposal. These plans are mostly for the refinement and improvement of the SCAN/Social Services model. Particular effort will be directed at improving the coordination between public agencies, private agencies, and volunteer groups within the communities.

APPENDIX D

FAMILY RESOURCE CENTER: ST. LOUIS, MISSOURI

PROLOGUE

The large, old house on Lindell Boulevard looks like several others on that street which have seen a change in use over the years from serving as elegant residences for St. Louisans to their current roles housing an array of small businesses. But, inside this particular building, Monday morning witnesses a series of activities very different from those of its neighbor businesses. Here on the second floor of the Family Resource Center, several children are participating in the Child Development Classroom, working sometimes on group activities such as drawing and singing and at other times on a one-to-one basis with the teachers and volunteers to develop some of the skills which they lack -- improving language skills, fine and gross motor activity, and their cognitive ability. On the first floor, many of their mothers are gathered in the Parents' Lounge for their weekly Group Therapy meeting, where they can share their problems and benefit from knowing that there are others who have similar experiences to their own.

On the third floor, in the Staff Lounge the volunteer Parent Counselors are meeting for their bi-weekly discussions of the parents they are working with and ideas on how to handle problems they encounter in their lay therapist roles.

Over in St. Louis Children's Hospital, which is a few blocks away but which is the parent agency for the Family Resource Center, the Child Abuse Coordinator who is a member of FRC's staff is running a seminar for new interns and nurses on the Emergency Room staff, on identifying and handling abuse cases.

The activities on this Monday morning are typical of the range of things being done at the Family Resource Center. Many of the parents and children will be returning to the Center at other times during the week, for the fathers' group, family counseling, recreational therapy or maybe for one of the special picnics or family activities the Center holds occasionally.

I. HISTORY

During late 1973 two students and a professor from the George Warren Brown School of Social Work at Washington University in St. Louis became concerned about the lack of treatment resources in the St. Louis community for families involved in abuse situations, other than those provided by the governmental agencies legally mandated to deal with the problems of child abuse and neglect. Consequently, the group began the development of a full-fledged treatment center, with services for the entire family. An organizational sponsor was needed for the program in St. Louis, and, based on the strong interest of the Director of the St. Louis Children's Hospital (SLCH) Department of Social Services, the decision was made to develop a hospital-based program, with St. Louis Children's as the sponsor.

The group, now including the hospital director of social services, wrote its grant proposal for the Family Resource Center (FRC), and began making community contacts to develop support for the potential program.

II. COMMUNITY CONTEXT

The City of St. Louis is one of the major urban centers in the country, and as such suffers from most of the problems associated with urban areas. With a population of 622,236 in 1970, St. Louis had 26.5% of its households below the poverty-income level and another 37.4% with incomes between $5000 and $10,000 per year.

The service delivery system for cases of abuse and neglect in the St. Louis community has been characterized by the presence of two focal agencies mandated by the child abuse law to receive all abuse reports, the Division of Family Services (DFS) and the Juvenile Court. Each receives reports and referrals of cases from other major agencies (hospitals, schools, police) for investigation and service planning or placement; but neither of the two refers cases elsewhere for investigation and service planning, except to each other. It is not, by any means, a centralized system. The two focal agencies do not see all abuse and neglect cases known to the other key agencies. And, for many of the cases which are seen by these two agencies, they are not the first agency to perform an investigation -- schools, hospitals, and the police all do their own investigations and some do diagnosis, service planning, and service provision before reporting the case to DFS or Juvenile Court. The level of coordination among agencies in the system has been low, with little interaction among agencies in terms of planning and training staff to achieve better service delivery for the community, and limited coordination and communication in the handling of individual cases.

III. PROJECT GOALS

The goals of the Family Resource Center are as follows:

1. To develop a family treatment approach which will reduce the incidence of abuse in FRC families by providing an educational and therapeutic environment for both parents and children;

2. To improve the child abuse service network in metropolitan St. Louis through establishing referral procedures with agencies for FRC families, identifying the nature and scope of FRC services for the agency network, involving agency staff in FRC meetings and initiating the expansion of services for abusive families through other agencies;

3. To provide a community education program which will develop greater awareness of the problem, improve the process of identifying and reporting suspected cases, improve attitudes toward abusive parents and their children, and encourage community support for programs servicing this population;

4. To organize training programs for professional, student and lay workers involved with abused children and their parents;

5. To expand the relevant knowledge base pertaining to child abuse by (a) participating in the national evaluation, (b) developing a process for conceptualizing program components for dissemination of the FRC model to the field, (c) determining methods for measuring behavior change in parents and children, (d) testing and diagnostic assessment of target child, (e) identification of characteristics of the clients, and (f) formulation of admission criteria.

IV. ORGANIZATIONAL STRUCTURE

The Center is a special project of SLCH's Department of Social Services. Its budget is covered almost totally by the federal demonstration monies, which are channeled through the hospital. The hospital provides some financial support in fringe benefits and other miscellaneous items. During its first year of operation, the project also has obtained limited local funding, securing a $4000 grant for its children's program and a $400 donation for special needs. The development of a local funding base has been an important objective of the Center from its inception, and staff continue to devote significant effort to this aim.

While housed organizationally in SLCH, the Center operates the bulk of its program out of its own facility, a large residence in close proximity to the hospital grounds. It functions semi-autonomously, with

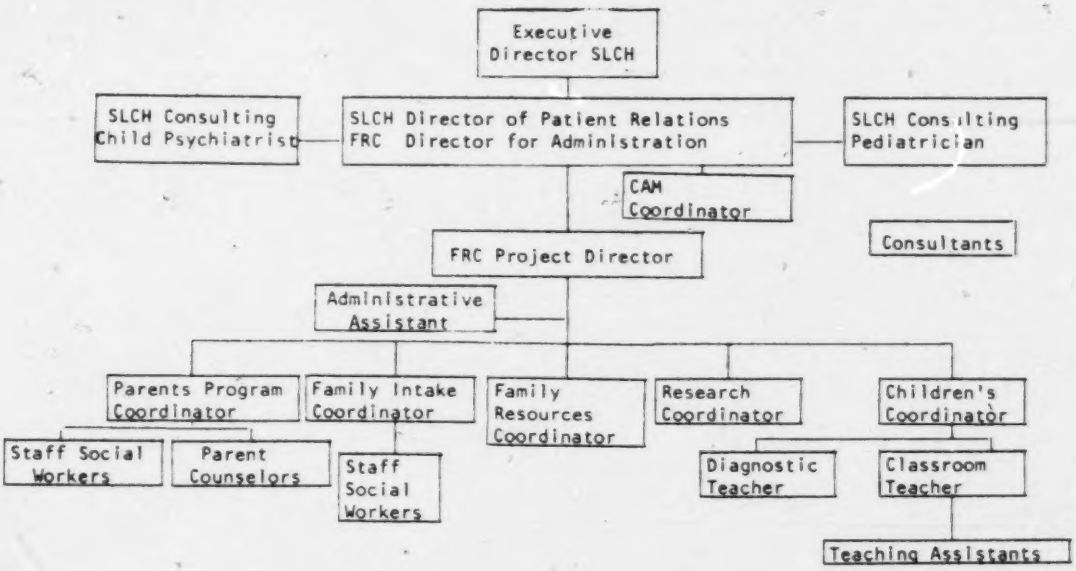
operational program and policy decisions resting primarily with the Center's Director. The hospital's Director of Social Services serves as the project's Director for Administration (a 20% time commitment), administering the hospital functions of the project, and participating with the Center Director in coordination of relations between the two facilities.

It is important to note that while the Center functions relatively autonomously of SLCH and derives only minimal financial support from the hospital, the tie to the hospital has been an important one for the Center, particularly in establishing credibility within the community.

V. STAFFING PATTERN

The staff organization of FRC includes five Program Coordinators, with responsibility for each of the distinct program areas of the Center, who work with the teaching, social work, and other volunteer staff in carrying out the Center's programs. The Project Director administers the program. In addition, a pediatrician and child psychiatrist from SLCH consult for the project and serve, with the Director for Administration, as the "collegial consultants" of the project, linking it to SLCH. Ultimate accountability, as the following organizational chart (Figure 1) illustrates, is to the hospital's Executive Director. An important characteristic of FRC is the use of students as an integral part of the staff. Students, participating in the Center for the practicum experience toward the MSW degree, commit a full year to the project and devote 15 to 20 hours weekly to the project on a regular schedule, handling their own cases or teaching responsibilities. The chart on the following page illustrates these staffing patterns.

FIGURE 1: Organizational Chart



VI. PROJECT COMPONENTS

Community Education: Community education is designed to make the community aware of the Center and the services it offers, to change attitudes and promote understanding about the problem of child abuse, and to make people knowledgeable about resources in the community system for dealing with the problem of abuse.

In addition to several presentations by or about FRC in the media, Center staff made 17 presentations during the first year to community groups, including community clubs, students, and prospective volunteers, on the dynamics of abuse, resources for reporting and treating abuse, and legal aspects of abuse. Over one million people were reached via media presentations and several hundred through direct group presentations.

Professional Education: The Center works with professionals from other agencies in the community to increase knowledge about child abuse and neglect, its identification and effective treatments. FRC has a slide presentation and video tapes that have been used 21 times by community agencies and hospitals. One hundred sixty agency representatives attended sessions on FRC at its community open house. Twenty presentations emphasizing forms of intervention and needs of abusive parents

have been made to professional groups, including nurses, social workers, physicians, teachers, staff of the Division of Family Services (DFS) and mixed groups.

A special emphasis in the professional education component is the training program provided by the CAM Coordinator to physicians, nurses and other staff of SLCH.

Coordination: A primary concern of the Center staff has been the establishment of working relationships with community agencies that have responsibilities for handling child abuse cases. The long-range goal of coordination is the development of an effective community network for providing services in abuse situations.

During its first year, FRC engaged in extensive coordination activities that resulted in the establishment of referral procedures with 11 agencies, procurement of a written agreement with the Division of Family Services (St. Louis City), participation in agency meetings to discuss FRC program design, and establishing a Parents Anonymous Chapter in St. Louis. In addition, the Center is increasing its contacts and coordination efforts with the county Division of Family Services as more and more of its referrals come from the county.

Legislation and Policy: During its first year, FRC staff worked with others in Missouri on drafting a proposed major revision of the child abuse law, and mental health legislation affecting children. The proposed law was researched and drafted by the Governor's Committee for Children and Youth, on which FRC had staff representation.

Research: The research efforts of the project have included the development and implementation of record-keeping in the project, including logs for client contacts, monthly reports on client status, children's records, and family summaries. In addition, the following research activities are being undertaken:

a. development of an expanded client characteristics questionnaire, which will be used to determine the characteristics of clients being screened out during the intake process versus those of clients being accepted into the Center;

b. performance of a series of tests (Denver Developmental, PPVT, Vineland and others) on all "target" children (i.e., abused children) whether or not they become active in the Center's children's programs, to characterize the developmental characteristics of abused children;

c. performance of a more in-depth series of tests (including McCarthy, Vallet, etc.) on all children enrolled in the Center's programs, to further refine the characterization of cognitive characteristics of abused children;

d. conceptualization of the treatment components of the program;

e. development of measures of behavioral change in parents and children.

Treatment Services

Individual Counseling and Therapy: The Center offers these services on a weekly basis to selected parents. While these treatment approaches are considered important for some cases, the Center does not use them as the primary treatment, depending on group work and the parent counselors for primary treatment and using individual work as needed. The Parents' Coordinator and Intake Coordinator currently do individual work, along with several of the student staff.

Parent Counselors: The Center now has six active parent counselors (or lay therapists). Each parent counselor has been assigned to one parent, and has made a commitment to the Center for at least one year. The Parent Counselor serves as the primary contact between the Center and the family. Their responsibilities include remaining available to the family on a 24-hour on-call basis, making frequent home visits, and establishing a trusting relationship which will allow the parent to turn to the counselor both in crisis situations and for a basically supportive relationship. For some parents the Parent Counselor is the only service they receive through the Center, while other parents with counselors are actively involved in additional project activities.

Group Therapy: Group therapy for parents is an important treatment service of the Center, which is offered to every parent. There are two active groups: a Mothers' Group and a Young Mothers' Group. Both groups meet weekly and are directed by two co-therapists.

Parents Anonymous: During its first year, the Center staff initiated the development of a PA chapter in St. Louis. In conjunction with a visit to the St. Louis area by Jolly K, founder of PA, the Center developed a publicity effort to attract parents who might benefit from PA, recruited sponsors and offered Center space for meetings. Currently, a PA group meets weekly at the Center with an outside sponsor, and a special PA telephone line has been established at the Center to receive calls and provide information to parents who are interested in joining the group.

Parent Education: During the first year, a six-session parent education program was provided for the Young Mothers' Group. In addition, education in child management or behavior management techniques is being provided for some parents on a one-to-one basis by the Children's Coordinator, usually in the parent's own home.

Crisis Intervention, Diagnosis and Referral: In addition to the availability of staff and Parent Counselors to respond to crises occurring in the families participating in Center programs, the project offers a special crisis intervention, diagnosis and referral service through the CAM Coordinator in SLCH. She responds to all cases of abuse identified at the hospital, meeting with the parents, assisting them in crisis situations, providing counseling as necessary and arranging an appropriate referral for the family, either for FRC services or to another community agency.

Child Development Classes: The child development program is designed for abused children who need remedial work in language, cognitive and motor development skills. It is designed for children between the ages of 2-1/2 and 5. The program, which includes half-day sessions five mornings a week, has as its primary focus individual "prescriptive" activity sessions tailored to each child's needs. The sessions are complemented by group activity and free play. Breakfast and a snack are included each day, and these meals are an integral part of the therapeutic program. Five to eight children participate at any given time. The program is under the direction of the Head Teacher who works with the Diagnostic Teacher, student teachers, and several volunteer child development aides. An expansion of the program to include an afternoon session for a second group of children is part of the project's second year efforts. This program will be focused on children with behavioral, rather than developmental, problems.

Play Therapy: Play therapy is used both for children beyond the age range of the Child Development Program, and as a complement to that program for some children who can benefit from both. The Children's Coordinator and some student social work staff provide this treatment.

Child Care: Students and other volunteers provide child care at the Center for children of mothers attending group therapy sessions, families attending family or marital counseling, and for parent counselors during the twice monthly meetings. This babysitting service also allows Center staff to have an opportunity to observe siblings of children in the Center's programs as well as abused children who are not involved in the Center's programs.

Transportation: The Center provides daily transportation to and from Child Development classes for all children, as well as taxi vouchers for parents who need transportation to and from the Center. In addition, some of the Center's services are provided in the parent's own home.

In addition to the services discussed above, the Center offers couples and family counseling, medical care, and testing services and special therapy through purchased service arrangements, and 24-hour crisis availability to parents in the program, through use of a "beeper" telephone system.

VII. PROFILE OF CLIENT CHARACTERISTICS

The Center served 23 families in its first year. Self-referral is the predominant source of clients for the Center, accounting for over one-third of the clients. Significant proportions of clients are referred from hospitals and the public social service agencies. Courts and law enforcement agencies have not been the source of referral on any cases yet accepted for services. All FRC cases must be abuse or potential abuse, but neglect is a factor in over one-fourth of these cases well. Almost half of the cases have had the abuse established, and only about 10% of the cases are simply potential abuse situations.

About 60% of the families have two parents in the home, legally married, with about one-fourth of the families being "single" parents, either divorced or separated. Almost half of the families are receiving public assistance, and one-fourth of the families have incomes of under $2000.

VIII. CLIENT FLOW

Identification: FRC receives about 25% of its referrals from SLCH, its parent agency; about 25% from the Division of Family Services; about one-third as self-referrals; and the remainder from a variety of agencies and individuals. All referrals are handled by the Intake Coordinator, who screens out cases clearly not appropriate to the project (about 15-20% of the calls, which he refers elsewhere). The project accepts only abuse cases.

Intake: For those cases not screened out at the point of initial referral, the Intake Coordinator makes in-person contact with the family, usually a home visit. Sometimes this is done by the Intake Coordinator alone, sometimes with a student social worker from the project, and sometimes accompanied by a staff person from the referral agency. Those cases that are not appropriate to the project, either because there is not a potential or actual abuse situation or because there are psychological problems of a type or severity inappropriate to the project, are referred elsewhere for help. The aim of the initial contact is to communicate FRC's desire to help, to explain what FRC offers, to clear up any confusion in the parent's mind about the legal aspects of the situation, and to begin to develop a relationship on which to base ongoing treatment. Participation in FRC's programs is completely voluntary.

Diagnosis and Treatment Planning: Weekly meetings are held by the Intake Coordinator, Parents' and Children's Program Coordinators and the Project Director to review cases received into intake. An initial plan is established and the case is assigned to a staff member for primary responsibility. The diagnosis phase will usually involve a series of

developmental tests given to the abused children in the family to determine their needs and whether Child Development or other children's programs would be appropriate. Following this diagnosis and treatment planning phase, parents are placed in the appropriate treatment service(s). One or both parents may be involved; children can be placed in the Center's programs only if the parent is involved in Center services.

Treatment: Both parents and children may participate in one or more of the Center's services. Staffings are held periodically on cases and each case is reviewed at three-month intervals at a case conference with the family present. Workers from DFS or other agencies active in the case are invited to participate in the review. At this time, progress is reviewed and new goals may be established, with the treatment plan being revised as appropriate. Length of time in treatment depends on the individual situation of the client.

Termination: Termination sometimes occurs because a family leaves the area or otherwise becomes unavailable for further treatment. The basic criteria for termination as a "successful" case is based on a judgment that family functioning has improved to the point where abuse has come under control for a given period of time and the family feels relatively secure. A child will be terminated from the Child Development Program when the developmental lags originally noted for the child have been remediated. Upon termination of a parent or child, FRC makes a referral to a community agency (day care, community mental health clinic, etc.) for continued work as appropriate. No specific follow-up has yet been formulated for parents. One child has been terminated from the program and follow-up is planned through observation of the child when the parents come in for couples counseling, as well as by contact with the day care center to which he has been referred.

IX. RESOURCE ALLOCATION

The total first year federal budget for the Center was $135,757. Approximately 60% of the project's resources go into case services, including intake and diagnosis as well as various forms of treatment. The Child DEvelopment program consumes the largest proportion of project resources (about 27%), being the major service for children. The combination of services for parents (counseling, therapy and education) represent about 11% of the project's resources. Staff development and training consume about 14% of the resources.

Unit costs for services vary from about $1.50 per contact for family counseling to $49.00 per contact for play therapy to over $200 for activities in handling a court case. Unit cost analysis for this project are probably premature at this time, since unit costs per contact are based not only on direct treatment contact time but also include costs

of planning and development of each service. Since the various services offered by the project are in different stages of development, some relatively stable but others new and requiring significant effort in planning and development, relative unit costs will be much higher for the latter.

X. IMPLEMENTATION ISSUES

The project has faced many issues in implementing its program. Certain issues have been specific to the Center's particular situation, but many are relevant for any new agency attempting to provide services in the child abuse field. Some of the most significant issues are discussed below.

Staffing: The relatively low salaries that could be offered, and the fact that the project is funded only for a specified period (and thus cannot necessarily offer indefinite job security) served to make finding staff difficult. Further, because the Center administrators could not find people with extensive experience in child abuse, they found it necessary to revise their experience criteria to include persons with backgrounds in working with families or children, and with some experience in, or dealing with, agencies in St. Louis.

One noteworthy positive experience of the project has been the use of student staff in the Center's programs. The practicum students working at FRC are an integral part of the staff, committing themselves to the project for a full year, and spending 15-20 hours per week at the project. Each student handles his or her own cases, providing individual counseling, doing case management, providing play therapy, serving as a child development teacher, or co-leading one of the therapy groups, under the direction of one of the professional staff.

Acceptance by Community Agencies: Instituting a new agency, outside the established legal network for receiving reports and referrals of child abuse and neglect cases, required major efforts in terms of developing cooperative arrangements with other community agencies. The Center experienced some normal resistance from other agencies, partly due to apprehensions that the Center would change established procedures for reporting and handling of child abuse, and partly to a sense on the part of agencies that the project was conceived and funded without their input.

Project Leadership and Decision Making: The original design for the FRC administration included a rather complex administrative structure: a collegial directorship (pediatrician 10%, child psychiatrist 10%, and social worker 30%), Associate Director for Treatment, and Associate Director for Administration. This design was constructed as an interdisciplinary management approach to child abuse and as a mechanism for incorporating SLCH personnel into the structure. Practical aspects

of management and decision making soon emerged, necessitating some revision in the rather cumbersome structure. Developing a decision-making model that incorporates staff input in an effective way remains a difficult problem.

Limited Staff and Resources: The most pressing problem identified by all staff during the first year has been the lack of adequate staff to respond to the treatment needs of parents. Staff limitations in a small Center preclude the provision of individualized therapy and counseling in all but a few cases, and thus group therapy and the use of volunteer Parent Counselors are seen as the primary treatment modes for parents.

Criteria for Acceptance: A problem related to the limitation in project resources is the need to identify a population for whom the Center's services can be beneficial, considering what the project can offer, and to develop criteria for accepting cases. Admission criteria were not initially designed by the project, which decided to "test out" several types of families to ascertain the particular families that could use the FRC services. General admission criteria now exist for identifying families to be accepted into the FRC program, or, alternatively, referred elsewhere. An intake screening instrument identifying parent characteristics, parents' attitudes toward children, and child characteristics, is used in the admission process.

Proportion of Time Spent in Direct Treatment: Staff members saw a significant portion of their time being spent in meetings, and in planning and implementing the Center's programs, leaving a smaller portion of their time for provision of direct treatment than they felt was desirable. The realization that they are part of a field in very developmental stages, without a set "technology" or all the "answers" to serving abusive families, has helped the staff to understand the need for spending so much time planning and implementing rather than doing, but it did not relieve the frustration.

Transportation: Transportation for parents and children has been a significant problem for the Center. A regular driver for the children has never been obtained on a long-term basis, and no Center vehicle is available, so that the driver must use his personal car or a staff member's car. Parent transportation is another problem. Most of the parents in the Center do not drive, and staff members spend significant amounts of time going out to the homes, and sometimes driving parents to the Center. The hospital provided taxi vouchers, as a donated resource, during the first year, but these will not continue. Staff feel that their experience indicates a need for planning for transportation of clients during the proposal writing stages to enhance the likelihood of achieving a reliable solution.

Channels of Communication with the Federal Funding Agency: Establishing clear communication concerning expenditures and other grant management matters has at times been a problem. The project feels that better communication channels at this level might have facilitated reaching solutions to other implementation problems.

XI. FUTURE PLANS

For the second year, the project is adding a second child development class, focused on abused children with behavioral problems.

With the addition of a Parent Staff Social Worker, the Center plans to increase its service capacity from about 25 families (current caseload) to 45 families. This will include expanded marital and family counseling, starting a couples' group, and possibly adding a third mothers' group. Having opened the Center one evening a week, for marital and family counseling and child care, the Center plans to remain open an additional evening. The evening hours allow more work with the family as a unit, by increasing the possibility of seeing all family members together.

APPENDIX E

OTHER RELEVANT DOCUMENTS

The following books and reports will provide the reader with valuable additional information and clarification specifically related to topics covered in this document.

General Child Abuse and Neglect

Many more books, reports, and articles on all facets of the child abuse and neglect problem have been prepared than can be presented in this document. The following publications outline many of these works.

Child Neglect, An Annotated Bibliography. Prepared by the Regional Institute of Social Welfare Research, University of Georgia, for the Social and Rehabilitative Service of the Department of Health, Education and Welfare (1975).

> The bibliography, dealing primarily with neglect, is divided into sections covering general works, prevention, identification, etiology, treatment, and sequellae; entries under each heading are fully described.

Hurt, Maure. Child Abuse and Neglect, a Report on the Status of the Research. Prepared for the Office of Child Development, Department of Health, Education and Welfare, D/HEW Publication (OHD) 74-20 (1974).

> This report contains both descriptions of the recently completed and ongoing research in child abuse and neglect, and an annotated bibliography. The research study descriptions are compiled under the categories of: (1) characteristics of abuse and neglect, (2) reporting, recording and diagnosis, and (3) remediation and the family.

Polansky, Norman; Hally, Carolyn; and Polansky, Nancy. Child Neglect: State of Knowledge. Prepared under a grant from the Social and Rehabilitative Service of the Department of Health, Education and Welfare to the Regional Institute of Social Welfare, Research, University of Georgia (1974).

The authors explore what is currently known about child neglect, the definition and prevalence of the problem, its etiology and identification and the prevention and treatment services most widely used to combat the problem.

Existing Child Abuse and Neglect Services

A Directory of Child Abuse Services and Programs. The National Center for Child Abuse and Neglect, Washington, D.C. (1976).

This directory, which is to be periodically updated, presents a listing of over 1500 child abuse services by D/HEW region. Entries include locations, contacts, purposes, services provided and a brief program description.

Child Protective Services, a National Survey. Prepared by staff of the American Humane Association, Children's Division (Denver) under a grant from the Child Welfare Foundation of the American Legion (1967).

Planning

Blum, Henrik L. and Associates. Health Planning. Comprehensive Health Planning Unit, School of Public Health, University of California, Berkeley (1969).

Delbecq, Andre L. and Van de Ven, Andrew. A Group Process Model of Problem Identification and Program Planning. Journal of Applied Behavioral Science, Vol. 7, No 4 (1971).

This paper describes the history of the Nominal Group Process, the procedures involved in applying the technique and its usefulness in various group settings to promote consensual decision-making.

Hargraves, W.A., Attkinnson, C.C., Siegel, L.M., McIntyre, M.H., and Sorensen, J.F. Resource Materials for Community Mental Health Program Evaluation, Part II: Needs Assessment and Planning.

This second of four resource books emphasizes the importance of the needs assessment phase of planning, provides useful guidance in the development and design of such studies and analyzes the adequacy of commonly available data and information.

Identifying Funding Sources/Proposal Writing

Lewis, Marianna O. (ed.) The Foundation Directory. Irvington, New York, Columbia University Press (1975).

The basic work in foundations, listing those foundations that have made in excess of $25,000 in a year, or who possess $500,000 plus in assets. Contains information on programs, personnel, and financial data.

Wilson, W. and B. Wilson. Grant Information System. Scottsdale, Arizona, the Oryx Press (1975).

A regularly updated, easy to use volume that groups grant programs by funding area (e.g., Health Field).

Executive Office of the President, Office of Management and Budget. 1974 Catalog of Federal Domestic Assistance. Washington, D.C., U.S. Government Printing Office.

This annual publication dealing with all federal funding programs is particularly useful when attempting to identify potential federal funding sources.

Hall, M. Developing Skills in Proposal Writing. Corvallis, Oregon, Continuing Education Publication (1972).

Urgo, Lewis A., and Robert J. Corcoran. A Manual for Obtaining Foundation Grants. Boston, Massachusetts, Robert J. Corcoran Company (1971).

Focuses specifically on approaching foundations. Contains examples of forms and formats which might be adapted when writing grant proposals.

Program Goals

Mager, Robert F. Goal Analysis. Fearon Publishers/Lear Siegler, Inc., Belmont, California (1972).

This book describes a process for clarifying goal statements, generating performance indicators for established goals, and plotting performance results to monitor goal achievement.

Protective Services

A Guide for State and Local Departments on the Delivery of Protective Services to Abused and Neglected Children and Their Families. U.S. Department of Health, Education and Welfare, Social and Rehabilitation Services (1976).

This guide, developed by Community Research Applications, Inc. under contract to Social and Rehabilitation Services, presents state and local administrators in public welfare and social service departments, with ideas for developing a responsive and comprehensive protective services program.

Comprehensive Emergency Services

Comprehensive Emergency Services, U.S. Department of Health Education and Welfare, Office of Child Development (1974).

This and several related publications, explain the Comprehensive Emergency Services System, developed by the National Center for Comprehensive Emergency Services to Children in Crisis in Nashville, Tennessee, designed to care for children in crisis due to family or community abuse or neglect.

Special Services for Children

Cohen, Donald and Brandegee, Ada. Serving Pre-School Children. U.S. Department of Health, Education and Welfare. Office of Child Development. DHEW Publication No. (OHD) 74-1057 (1974).

One of a series of booklets on day care, this handbook explores numerous issues related to developing day care programs for pre-schoolers, including program administration, budgeting, licensing, facilities, curricula, staffing, and the provision of health/nutritional services. There is a comprehensive overview of the

pre-school child's development and descriptions of exemplary centers.

Day Care Evaluation Manual. Prepared by staff of the Council for Community Services in Metropolitan Chicago for the Office of Child Development. Publication No. 7502 (1974).

This very extensive manual presents the rationale for the evaluation of day care services and describes the procedures and processes of applying the evaluation system outlined in the Manual. Twenty-seven separate evaluation questionnaires, mostly in check-list form, covering every aspect of day care program administration, physical facilities, staff, licensing, and services are included in the manual.

Standards for Foster Family Services Systems with Guidelines for Implementation Specifically Related to Public Agencies. American Public Welfare Association, Washington, D.C. (1975).

This easy-to-read report presents both basic and optimum standards for foster care agencies in areas such as legislation, facilities and equipment, standard development, rights of children and parents, community education, staff, case records, recruitment of foster families, volunteer services, evaluation services and many other important foster care related topics.

Evaluation

Clinic Self-Evaluation Manual for the Determination and Improvement of Clinic Efficiency. Prepared by Neil Sims, M.D., the Johns Hopkins University School of Medicine and Health Systems, Department of Westinghouse Electric Corporation for the Department of Health, Education and Welfare, Maternal and Child Health Services (revised 1971).

This comprehensive, indexed manual provides guidelines and sample formats which allow clinic directors to evaluate the efficient utilization of facilities and manpower, and the effectiveness of services and appears easily adaptable to most direct service programs. The manual deals with documenting clinic objectives, administration procedures, resource expenditures, client flow analysis, work sampling (quality), and the interpretation and utilization of study results.

Suchman, Edward A. Evaluative Research: Principles and Practice in Public Service and Social Action Programs. New York, Russell Sage Foundation (1967).

A classic volume on evaluation research with emphasis on the health and medical care fields.

Weiss, Carol H. (ed.) Evaluating Action Programs: Readings in Social Action and Education. Boston, Allyn and Bacon, Inc., (1972).

A well-organized volume of practical articles dealing with evaluation.

Other Federal Publications of Interest

Model Child Protective Services Act with Commentary (March 1, 1976) DRAFT.

Report of the U.S. Department of Health, Education and Welfare to the President and Congress of the United States on the Implementation of Public Law 93-247, the Child Abuse Prevention and Treatment Act (August 1975).

Working with Abusive Parents from a Psychiatric Point of View, DHEW (OHD) 75-70.

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Research, Demonstration, and Evaluation Studies on: "Child Abuse and Neglect". The Intradepartmental Committee on Child Abuse and Neglect, Fiscal Year 1974, DHEW (OHD) 75-77.